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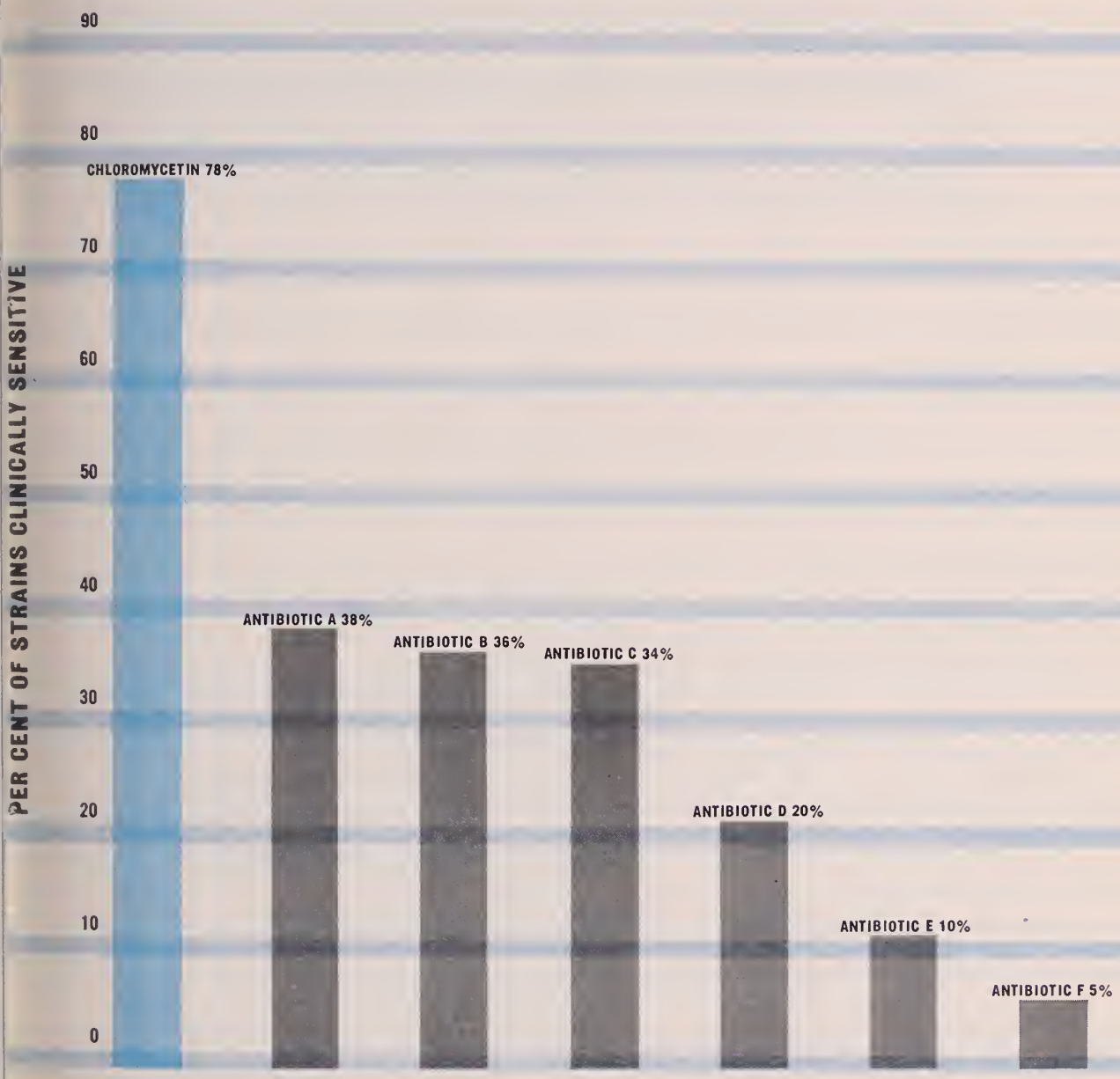

*This graph is adapted from Waisbren and Strelitzer.[15] It represents *in vitro* data obtained with clinical material isolated between the years 1951 and 1956. Inhibitory concentrations, ranging from 3 to 25 mcg. per ml., were selected on the basis of usual clinical sensitivity.

JUN 4 1959

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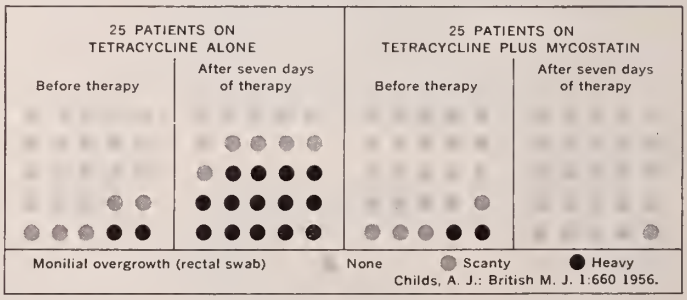

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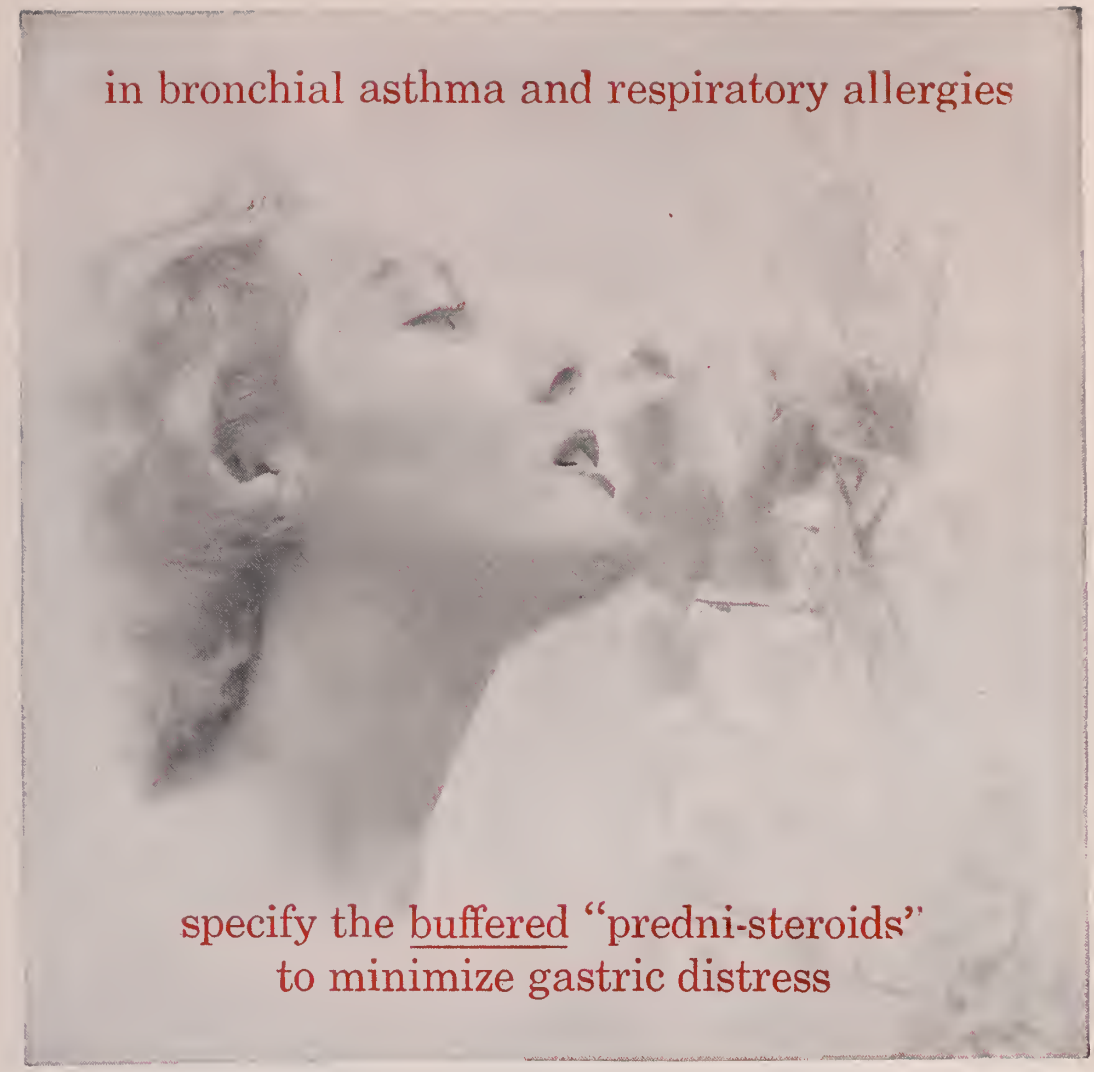

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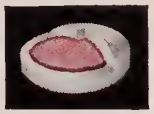

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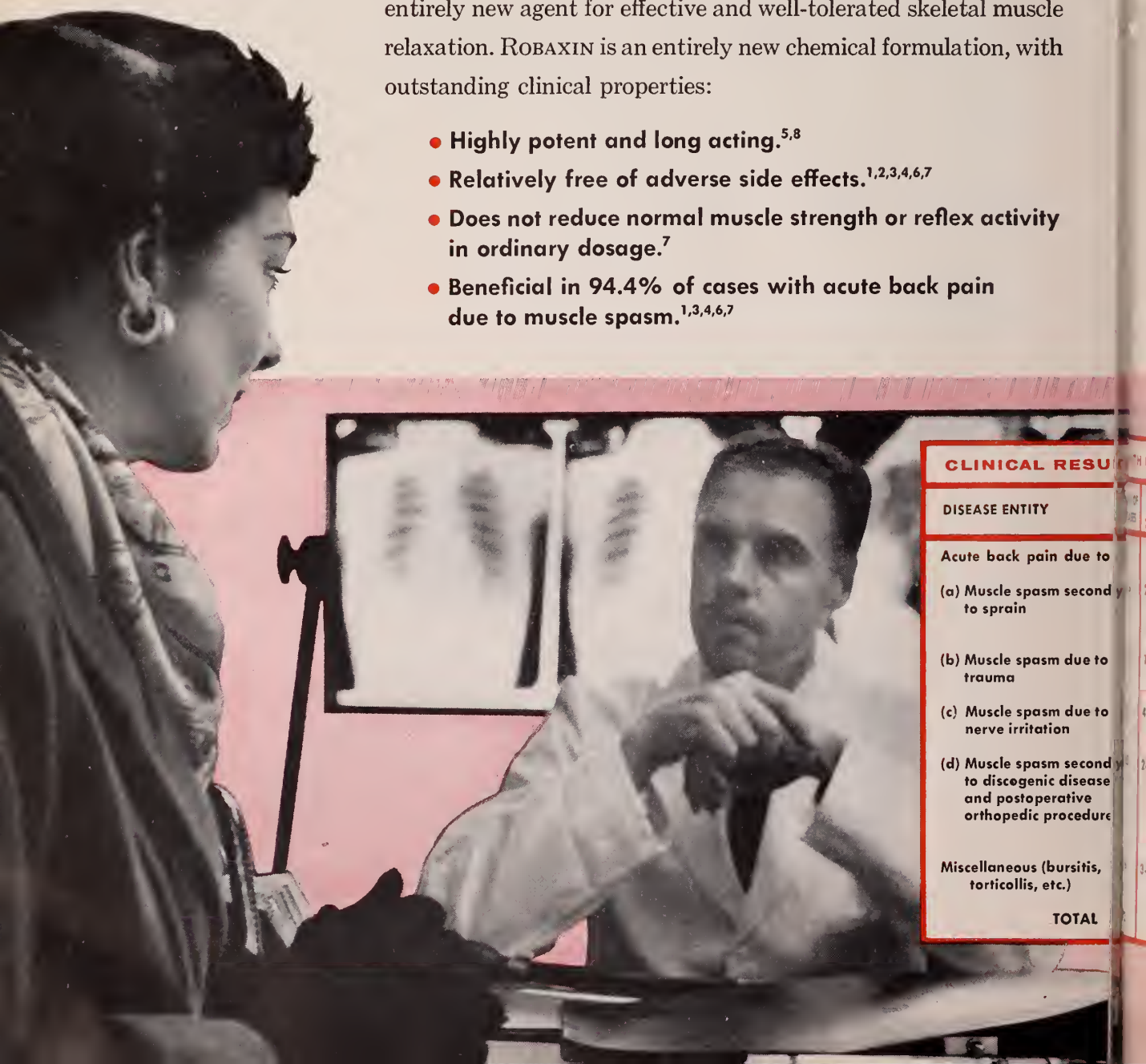

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Acute back pain due to	
(a) Muscle spasm second y to sprain	
(b) Muscle spasm due to trauma	
(c) Muscle spasm due to nerve irritation	
(d) Muscle spasm second y to discogenic disease and postoperative orthopedic procedure	
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10	2-28 days	1.5-9 Gm.	24	3	0	3	None, 25 Dizziness, 1 Lightheadedness, 2 Nausea, 2 *
6	3-60 days	4-8 Gm.	6	0	0	0	None, 6
2			59	6	3	4	*Relieved on reduction of dose

References: 1. Carpenter, E. B.: Publication pending. 2. Carter, C. H.: Personal communication. 3. Forsyth, H. F.: Publication pending. 4. Freund, J.: Personal communication. 5. Morgan, A. M., Truitt, E. B., Jr., and Little, J. M.: American Pharm. Assn. 46:374, 1957. 6. Nachman, H. M.: Personal communication. 7. O'Doherty, D.: Publication pending. 8. Truitt, E. B., Jr., and Little, J. M.: J. Pharm. & Exper. Therap. 119:161, 1957.

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Surgery of Hernia, Three Days, April 3
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on a **SINGLE** intramuscular dose, in minimal injection volume

This achievement is made possible by the unique solubility of TETREX (tetracycline phosphate complex), which permits *more* antibiotic to be incorporated in *less* volume of diluent. Clinical studies have shown that injections are well tolerated, with no more pain on injection than with previous, less concentrated formulations.

TETREX Intramuscular '250' can be reconstituted for injection by adding 1.6 cc. of sterile distilled water or normal saline, to make a total injection volume of 2.0 cc. When the entire 250 mg. are to be injected, and minimal volume is desired, as little as 1.0 cc. of diluent need be used. (Full instructions for administration and dosage for adults and children, accompany packaged vial.)

Each one-dose vial of TETREX Intramuscular '250' contains:

TETREX (tetracycline phosphate complex) (tetracycline HCl activity).....**250 mg.**

Xylocaine* hydrochloride ..... **40 mg.**

plus ascorbic acid 300 mg. and magnesium chloride 46 mg. as buffering agents.

**® of Astra Pharm. Prod. Inc. for lidocaine*

SUPPLY: Single-dose vials containing TETREX — tetracycline phosphate complex — each equivalent to 250 mg. tetracycline HCl activity. Also available in 100-mg. single-dose vials.

INTRAMUSCULAR '250' WITH XYLOCAINE

RISTOL LABORATORIES INC., SYRACUSE, NEW YORK

See anybody here you know, Doctor?

I'm just too much

AMPLUS®

for sound obesity management
dextro-amphetamine plus vitamins
and minerals

I'm too little

STIMAVITE®

stimulates appetite and growth
vitamins B_1, B_6, B_{12}, C and L-lysine

I'm simply two

OBRON°

a nutritional buildup for the OB patient

OBRON° HEMATINIC

when anemia complicates pregnancy

And I'm getting brittle

NEOBON°

5-factor geriatric formula
hormonal, hematinic and
nutritional support

With my anemia,
I'll never make it up
that high

ROETINIC®

one capsule a day, for all treatable anemias

HEPTUNA° PLUS

when more than a hematinic is indicated

(Prescription information on request)

. . . solve their problems with a nutrition product from ROERIG

New York 17, New York
Division, Chas. Pfizer & Co., Inc.

SACRED HEART SANITARIUM

MILWAUKEE, WISCONSIN

An institution conducted for the diagnosis and treatment of mild nervous disorders and non-infectious diseases; also for rest and recuperation under medical supervision. Equipped with every modern facility for diagnostic purposes. Scientific dietetics, physiomechanotherapy, hydrotherapy, supervised occupational and recreational activities. Literature and rates sent on request.

MEDICAL STAFF

William L. Herner, M. D., Medical Director

John F. Wyman, M. D.
Hubert H. Blanchard, M. D.
John E. Leach, M. D.
Lloyd F. Jenk, M. D.
Richard O. Barnes, M. D.
John R. Whitty, M. D.
Preston W. Thomas, M. D.

when anxiety and tension "erupts" in the G. I. tract...

IN DUODENAL ULCER

PATHIBAMATE*

Meprobamate with PATHILON® Lederle

Combines Meprobamate (*400 mg.*) the most widely prescribed tranquilizer . . . helps control the "emotional overlay" of duodenal ulcer — without fear of barbiturate loginess, hangover or habituation . . . *with* PATHILON (*25 mg.*) the anticholinergic noted for its extremely low toxicity and high effectiveness in the treatment of many G.I. disorders.

Dosage: 1 tablet t.i.d. at mealtime. 2 tablets at bedtime. *Supplied:* Bottles of 100, 1,000.

*Trademark ® Registered Trademark for Tridihexethyl Iodide Lederle

Lederle LEDERLE LABORATORIES DIV. AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

BARR X-RAY CO., INC.

1924 W. Clybourn St. WEst 3–1300
MILWAUKEE 3, WISCONSIN

Has available at all times a complete line of film and chemicals, plus the equipment and accessory items needed to make your X-ray department operate efficiently.

"After the Sale It's the Service That Counts"

ORTHOPEDIC APPLIANCES of every description since 1909. Certified Prosthetic Mechanics and Fitters for Men and Women are your guarantee of careful, specialized cooperation.

THE ORTHOPEDIC APPLIANCE CO., Inc.

123 East Wells Street Milwaukee 2, Wisconsin
Telephone BR 6–3021

Malpractice Prophylaxis

AVOID LOOSE TALK,
THE ILL WIND
THAT BLOWS NO GOOD

Specialized Service makes our doctor safer

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

MILWAUKEE Office:
M. M. Morehart, Rep.,
743 N. 4th Street,
Telephone Broadway 6-1021

Superior for acne cleansing

The greatest benefit in acne therapy comes to those patients who use pHisoHex® often and daily in conjunction with other standard measures.

For best results, prescribe from four to six pHisoHex washings of the acne area daily.

pHisoHex cleans better than soap, degerms rapidly, prevents bacterial growth, and maintains normal skin pH.

pHisoHex®

Sudsing, nonalkaline antibacterial detergent—nonirritating, hypoallergenic. Contains 3% hexachlorophene.

Winthrop LABORATORIES
New York 18, N.Y.

pHisoHex, trademark reg. U. S. Pat. Off.

the chill

the cough

the aching muscles

the fever

Viral upper respiratory infection. . . . For this patient, your management will be twofold—prompt symptomatic relief plus the prevention and treatment of bacterial complications. PEN•VEE•*Cidin* backs your attack by broad, multiple action. It relieves aches and pains, and reduces fever. It counters depression and fatigue. It alleviates cough. It calms the emotional unrest. And it dependably combats bacterial invasion because it is the only preparation of its kind to contain penicillin V.

SUPPLIED: Capsules, bottles of 36. Each capsule contains 62.5 mg. (100,000 units) of penicillin V, 194 mg. of salicylamide, 6.25 mg. of promethazine hydrochloride, 130 mg. of phenacetin, and 3 mg. of mephentermine sulfate.

PHYSICIANS' COUNCIL · INFORMATION ON CHILD HEALTH

This advertisement conforms to the Code for Advertising of the Physicians' Council for Information on Child Health.

PEN · VEE · *Cidin*®

Wyeth®

Penicillin V with Salicylamide, Promethazine Hydrochloride, Phenacetin, and Mephentermine Sulfate, Wyeth

Philadelphia 1, Pa.

"...especially suitable for out-patient and office use."†

†Ayd, F. J., Jr.: The Treatment of Ambulatory and Hospitalized Psychiatric Patients with Trilafon, presented at Ann. Meet., Am. Psychiat. Assoc., Chicago, Ill., May 13-17, 1957.

Trilafon*

(pronounced Trĭll'-ah-fon) perphenazine

the full-range tranquilizer

EXCEPTIONAL THERAPEUTIC RANGE

. . . dosage range adaptable for tension and anxiety states, ambulatory psychoneurotics, agitated hospitalized psychotics

EXCEPTIONAL POTENCY

- At least five times more potent than earlier phenothiazines

EXCEPTIONAL ANTIEMETIC RANGE

- From the mildest to the severest nausea and vomiting due to many causes

ADEQUATE SAFETY IN RECOMMENDED DOSAGE RANGES

- Jaundice attributable to the drug alone not reported
- Unusual freedom from significant hypotension
- No agranulocytosis observed
- Mental acuity apparently not dulled

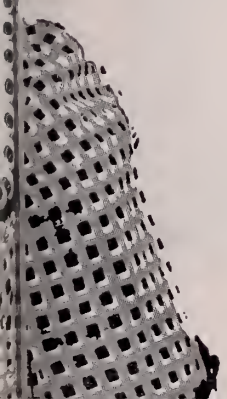
TRILAFON—grey tablets of 2 mg. (black seal), 4 mg. (green seal), 8 mg. (blue seal), bottles of 50 and 500; 16 mg. (red seal), for hospital use, bottle of 500.

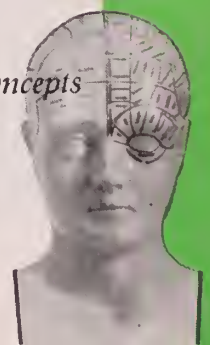
Refer to Schering literature for specific information regarding indications, dosage, side effects, precautions and contraindications.

SCHERING CORPORATION • BLOOMFIELD, NEW JERSEY

*T.M. TR-J-3297

outmoding older concepts





Schering

key to oral penicillin effectiveness

V-CILLIN K

(Penicillin V Potassium, Lilly)

stability plus solubility provides greater absorption

—twice as much absorption of penicillin as from buffered potassium penicillin G given orally.

A greater total penicillemia is produced by 250 mg. of 'V-Cillin K' t.i.d. than by 600,000 units daily of intramuscular procaine penicillin G. Also, high serum levels are attained more quickly with this new oral penicillin.

These unique advantages of 'V-Cillin K' assure maximum penicillin effectiveness, and dependable therapy, for penicillin-sensitive infections.

Scored tablets of 125 and 250 mg. (200,000 and 400,000 units).

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.

833203

Lilly

QUALITY / RESEARCH / INTEGRITY

SEARLE *announces...*

a superior psychochemical
for the management of both
minor and major
emotional disturbances

Dartal T. M.

dihydrochloride brand of thiopropazate dihydrochloride

- more effective than most potent tranquilizers
- as well tolerated as the milder agents
- consistent in effects as few tranquilizers are

Dartal is a unique development of Searle Research, proved under everyday conditions of office practice

It is a single chemical substance, thoroughly tested and found particularly suited in the management of a wide range of conditions including psychotic, psychoneurotic and psychosomatic disturbances.

Dartal is useful whenever the physician wants to ameliorate psychic agitation, whether it is basic or secondary to a systemic condition.

In extensive clinical trial Dartal caused no dangerous toxic reactions. Drowsiness and dizziness were the principal side effects reported by non-psychotic patients, but in almost all instances these were mild and caused no problem.

Specifically, the usefulness of Dartal has been established in psychoneuroses with emotional hyperactivity, in diseases with strong psychic overtones such as ulcerative colitis, peptic ulcer and in certain frank and senile psychoses.

Usual Dosage
- In psychoneuroses with anxiety and tension states *one 5 mg. tablet t.i.d.*
- In psychotic conditions *one 10 mg. tablet t.i.d.*

newest antibiotic therapy for the eye
...spreads in a wink

ACHROMYCIN*

TETRACYCLINE

OPHTHALMIC OIL

SUSPENSION 1%

no sting

no smear

no cross contamination

...Just drop on eye...spreads in a wink! Provides unsurpassed antibiotic efficacy in a wide range of common eye infections...dependable prophylaxis following removal of foreign bodies and treatment of minor eye injuries.

SUPPLIED: 4 cc. plastic squeeze, dropper bottle containing ACHROMYCIN Tetracycline HCl (1%) 10.0 mg., per cc., suspended in sesame oil...retains full potency for 2 years without refrigeration.

*Reg. U. S. Pat. Off.

Lederle LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

. . . . THE PRESIDENT'S PAGE . . . .

IT SEEMS appropriate at this time to make a brief report on a few of the activities of the first six months of my tenure of office as your president. It would be helpful to share with you my thinking by directing your attention to some of the matters I deem especially worthy of consideration and action in the months that lie just ahead.

The doctors of Wisconsin have by repeated declaration and ever-recurring past actions irrevocably dedicated themselves to the supreme task of maintaining health standards in this state at the highest level. This must and will be done at all costs. In the words of Carlyle, "The block of granite which is an obstacle in the pathway of the weak becomes a stepping stone in the pathway of the strong."

Unity among doctors of medicine must be paramount and of continuing concern for this year and for every year. For unity there is no substitute. To work together for the improvement of our profession, to strive together for the protection and betterment of public health is impossible without a closely knit and vigorous organization. Our achievements will rest not only in capable leadership but in the united efforts of our many members.

Ranking high among our objectives this year is the ever-important matter of medical teaching of the busy practicing doctor. Our circuit teaching program has carried the major load admirably in keeping the doctor abreast of the ever-increasing medical advances and practices. The teaching program, however, must be broadened by coming to the aid of such county medical societies as have difficulties in securing speakers and programming material suitable to their particular needs.

The expansion of Blue Shield tailored to more adequately meet the needs of the people and the doctor is essential for the continued success of this popular form of medical and surgical insurance. Special contracts providing for payments of usual and customary fees to the doctor are the most recent significant development.

A special study of medical care in the hospital is looming over the horizon. It will be launched on a state-wide basis soon.

The month of May will soon be upon us and, with it, the one hundred and seventeenth Annual Meeting of the State Medical Society at Milwaukee will highlight the year's activities. Present plans indicate that the meeting will be one of our best.

In June the American Medical Association will meet in San Francisco. This will mark one of the greatest triumphs of the Badger State in the last fifty years of medical history—the inauguration of Dr. Gunnar Gundersen of La Crosse as president of the American Medical Association.

Later in the year we hope to see another major event in Wisconsin medicine's long and illustrious history—the opening of restored Fort Crawford Hospital as a part of the Medical Museum of Wisconsin at Prairie du Chien.

In our zeal for better medical care for our own countrymen, we may have overlooked the tragic fact that thousands of people in foreign lands, by American standards, receive no medical care at all. The World Medical Association is organized in part to be an instrumentality whereby this social injustice might be removed. I strongly urge all Wisconsin physicians to include support of the World Medical Association among matters worthy of consideration and action.

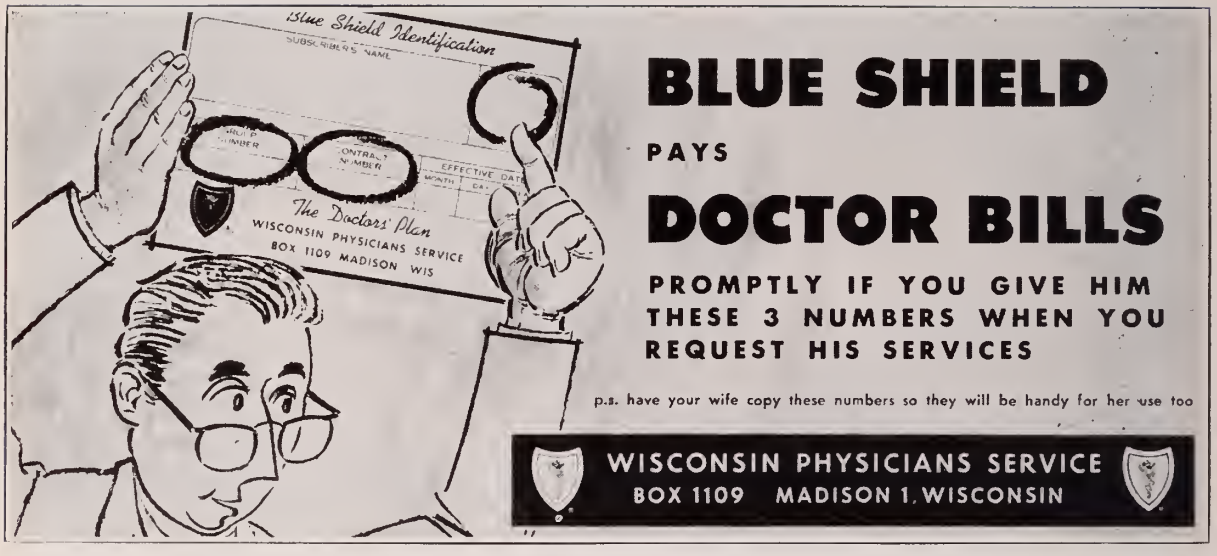
Harry E. Kasten, M.D.

"THE DOCTORS' PLAN"

THE BLUE SHIELD PLAN
OF THE
STATE MEDICAL SOCIETY OF WISCON

Facts about WISCONSIN PHYSICIANS SERVICE

PREPARED BY THE COMMISSION ON MEDICAL CARE PLANS



Patients Being Educated in Use of Identification Card

More than 100,000 pieces of literature will be distributed to Wisconsin Physicians Service contract holders during the next few months in an extensive effort to educate subscribers and their families on the use of the Blue Shield identification card.

First, nearly 5,000 colorful 11 by 14 inch posters will be distributed to all Wisconsin Physician Service groups for posting on company bulletin boards and in employee lounges. Its message:

> "Blue Shield pays doctor bills promptly if you give him these three numbers when you request his services."

A similar message is being used on the blotter-type mail insert illustrated above. Many Wisconsin Physicians Service groups will distribute these reminders for use of the identification card to their employees in their pay check envelopes. All direct-pay non-group subscribers will receive the notice with their next premium billing. In addition, the inserts will be sent along with benefit payment notices regularly mailed to subscribers for whom W.P.S. has paid a claim.

Physicians who wish to use the inserts to mail to patients may obtain a supply upon request to Wisconsin Physicians Service. A copy of the blotter posted on the doctor's office bulletin board or placed at the reception desk may serve as a reminder to patients to report their ID card numbers.

For Information or Advice

Write P. O. BOX 1109, MADISON, WIS. Phone ● ALpine 6-3101 MADISON, WIS.

The State Medical Society of Wisconsin

1957–58 Officers and Councilors

President

Dr. H. E. Kasten
419 Pleasant Street
Beloit

President–Elect

Dr. J. W. Fons
3333 South 27th Street
Milwaukee

Secretary

Mr. C. H. Crownhart
330 East Lakeside Street
Madison

Assistant Secretaries

Mr. Roy T. Ragatz
Mr. Earl R. Thayer
330 East Lakeside Street
Madison

Treasurer

Dr. F. L. Weston
1 South Pinckney
Madison

Speaker, House of Delegates

Dr. W. B. Hildebrand
216½ Main Street
Menasha

Councilors*

(Dr. R. G. Arveson, Frederic, Chairman)

First: Dodge, Jefferson and Waukesha County Societies. Dr. W. D. James, Oconomowoc, 1960.

Second: Kenosha, Racine and Walworth County Societies. Dr. L. H. Lokvam, 723 58th Street, Kenosha, 1960.

Third: Dane, Columbia–Marquette–Adams, Green, Rock and Sauk County Societies. Dr. N. A. Hill, 304 West Washington Avenue, Madison, 1958; Dr. J. H. Houghton, 132 Washington Avenue, Wisconsin Dells, 1960.

Fourth: Crawford, Grant, Iowa, Lafayette and Richland County Societies. Dr. E. M. Dessloch, Prairie du Chien, 1958.

Fifth: Calumet, Manitowoc, Sheboygan and Washington–Ozaukee County Societies. Dr. A. H. Heidner, West Bend, 1958.

Sixth: Brown, Door–Kewaunee, Fond du Lac, Outagamie and Winnebago County Societies. Dr. G. W. Carlson, 228 West College Avenue, Appleton, 1958.

Seventh: Juneau, La Crosse, Monroe, Trempealeau–Jackson–Buffalo and Vernon County Societies. Dr. J. C. Fox, 212 South 11th Street, La Crosse, 1959.

Eighth: Marinette–Florence, Oconto, and Shawano County Societies. Dr. J. M. Bell, Marinette, 1959.

Ninth: Clark, Green Lake–Waushara, Lincoln, Marathon, Portage, Waupaca and Wood County Societies. Dr. R. E. Garrison, Wisconsin Rapids, 1959.

Tenth: Barron–Washburn–Sawyer–Burnett, Chippewa, Eau Claire–Dunn–Pepin, Pierce–St. Croix, Polk and Rusk County Societies. Dr. R. G. Arveson (chairman), Frederic, 1959.

Eleventh: Ashland–Bayfield–Iron and Douglas County Societies. Dr. V. E. Ekblad, 1507 Tower Avenue, Superior, 1960.

Twelfth: The Medical Society of Milwaukee County. Dr. R. E. Galasinski, 3333 South 27th Street, Milwaukee; Dr. G. S. Kilkenny, 2040 West Wisconsin Avenue, Milwaukee, 1960; Dr. J. P. Conway, 1800 East Capitol Drive, Milwaukee, 1958; Dr. James E. Conley, 425 East Wisconsin Avenue, Milwaukee; Dr. E. L. Bernhart, 2714 West Burleigh Street, Milwaukee, 1959.

Thirteenth: Forest, Langlade, Oneida–Vilas and Price–Taylor County Societies. Dr. J. D. Leahy, Park Falls, 1959.

Dr. L. O. Simenstad, Osceola (past president).

Dr. S. E. Gavin, 104 South Main Street, Fond du Lac, Chairman Emeritus.

Delegates to American Medical Association

Dr. S. E. Gavin (1958)
104 South Main Street
Fond du Lac

Dr. D. H. Witte (1958)
3300 West Wisconsin Avenue
Milwaukee

Dr. W. D. Stovall (1959)
State Laboratory of Hygiene
Madison

Dr. J. C. Griffith (1959)
944 North Jackson Street
Milwaukee

Alternates

Dr. L. O. Simenstad (1958)
Osceola

Dr. E. L. Bernhart (1958)
2714 West Burleigh Street
Milwaukee

Dr. A. A. Quisling (1959)
2 West Gorham Street
Madison

Dr. R. E. Galasinski (1959)
3333 South 27th Street
Milwaukee

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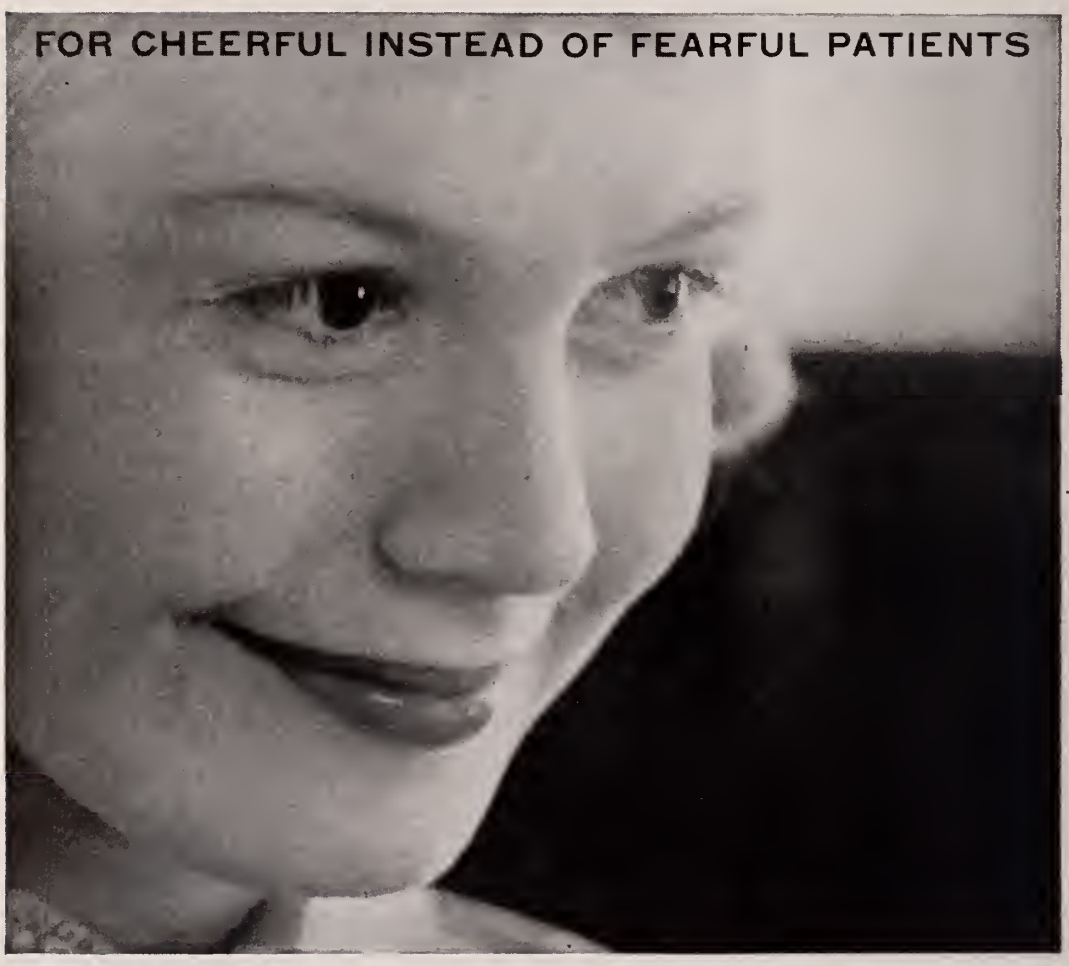
* Map indicating location of councilor districts, page 37.

Note: Officers, councilors, delegates, and members of Standing Committees are elected at the Annual Meeting in May.

both-
orally for
dependable prophylaxis-
sublingually for
fast relief

NEW ISUPREL®-



FRANOL® TABLETS

ASTHMATIC –
but cheerful instead of fearful

New Isuprel-Franol tablets bring round-the-clock relief *plus* emergency help against sudden attack. Anxiety stops when patients know they'll get relief in 60 seconds — relief that continues for four hours or more.

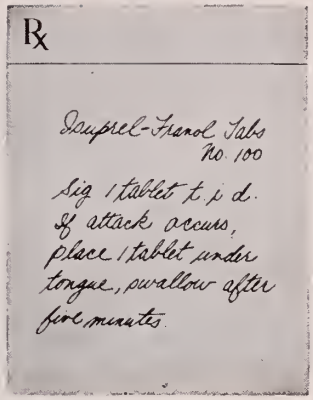
Isuprel HCl (10 mg. for adults, 5 mg. for children), the most potent bronchodilator known, makes up the outer coating. In a sudden attack, the patient puts the tablet under his tongue. Relief starts in 60 seconds. A unique feature is the "flavor-timer." As the Isuprel is absorbed a lemon flavor appears. When it disappears—about five minutes later — the patient swallows the tablet.

An unexcelled combination for prolonged bronchodilatation makes up the Isuprel-Franol core: benzylephedrine HCl (32 mg.), Luminal® (8 mg.) and theophylline (130 mg.). Swallowed, the tablet works for four hours or more.

Isuprel-Franol tablets are "... effective in controlling over 80% of patients with mild to moderate attacks of asthma."[1]

1. Fromer, J. L., and DeRisio, V. J.: *Lahey Clin. Bull.* 10:45, Oct.-Dec., 1956.

Winthrop LABORATORIES
New York 18, N. Y.

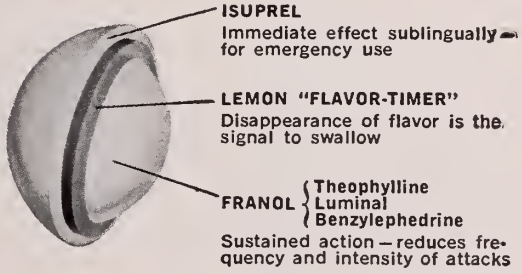


ISUPREL-FRANOL tablets (Isuprel HCl 10 mg.) for adults;
ISUPREL-FRANOL Mild tablets (Isuprel HCl 5 mg.) for children:

One tablet every three or four hours taken *orally* for continuous control of bronchospasm in chronic asthma. One tablet taken *sublingually* for sudden attack. "Flavor-timer" signals when patient should swallow.

Bottles of 100 tablets.

"Flavor-timer" signals patients when to swallow tablets



ISUPREL (BRAND OF ISOPROTERENOL), FRANOL AND LUMINAL (BRAND OF PHENOBARBITAL), TRADEMARKS REG. U. S. PAT. OFF

Standing Committees—1957-1958

Committee on Cancer

R. C. Cantwell, M.D., 1958, chairman, Clinic Building, Shawano

R. P. Welbourne, M.D., 1960, 113 North Third Street, Watertown

A. R. Curreri, M.D., 1958, 1300 University Avenue, Madison

W. S. Bump, M.D., 1959, 1020 Kabel Avenue, Rhinelander

E. C. Howell, M.D., 1959, Fennimore

Paul M. Cunningham, M.D., 1960, 401 North Oneida Street, Appleton

P. B. Blanchard, M.D., 1960, Cedarburg

Clifford A. Grand, M.D., 1960, 522 West Second Street, Ashland

R. B. Larsen, M.D., 1958, 510½ Third Street, Wausau

G. I. Uhrich, M.D., 1959, 212 South Eleventh Street, La Crosse

Ralph C. Frank, M.D., 1959, Pine Place, Route 3, Eau Claire

R. J. Schacht, M.D., 1959, 1704 Milwaukee Avenue, Racine

Carlton Wirthwein, M.D., 1959, 425 East Wisconsin Avenue, Milwaukee

Committee on Grievances

R. E. Fitzgerald, M.D., 1960, chairman, 2218 North Third Street, Milwaukee

E. W. Mason, M.D., 1959, 324 East Wisconsin Avenue, Milwaukee

E. D. Sorenson, M.D., 1959, Elkhorn

F. C. Lane, M.D., 1960, Merrill

F. A. Nause, M.D., 1958, 927–A North Eighth Street, Sheboygan

H. W. Wirka, M.D., 1958, 1300 University Avenue, Madison

C. D. Neidhold, M.D., 1960, 103 West College Avenue, Appleton

C. B. Hatleberg, M.D., 1958, 206 Bridge Street, Chippewa Falls

J. L. Moffett, M.D., 1959, 107 East Main Street, Platteville

Committee on Hospital Relations

W. C. Henske, M.D., 1959, chairman, 3½ East Spring Street, Chippewa Falls

W. B. Hildebrand, M.D., 1958, 216½ Main Street, Menasha

A. H. Barr, M.D., 1960, 214 North Wisconsin Street, Port Washington

S. R. Beatty, M.D., 1960, 117 North Commercial Street, Neenah

Arthur J. McCarey, M.D., 1958, 305 East Walnut Street, Green Bay

S. W. Hollenbeck, M.D., 1959, 2650 West Fond du Lac Avenue, Milwaukee

Committee on Medical Education and Hospitals

T. L. Squier, M.D., 1961, chairman, 425 East Wisconsin Avenue, Milwaukee

N. M. Clausen, M.D., 1958, 2 West Gorham Street, Madison

I. E. Schiek, Jr., M.D., 1959, 114 West Davenport Street, Rhinelander

J. W. Boren, Jr., M.D., 1960, 1510 Main Street, Marinette

W. S. Freeman, M.D., 1962, 1146 Grant Street, Beloit

John Z. Bowers, M.D., ex officio, 1300 University Avenue, Madison

J. S. Hirschboeck, M.D., ex officio, 561 North Fifteenth Street, Milwaukee

Committee on Coordination of Medical Services

R. S. Gearhart, M.D., 1960, chairman, 621 South Park Street, Madison

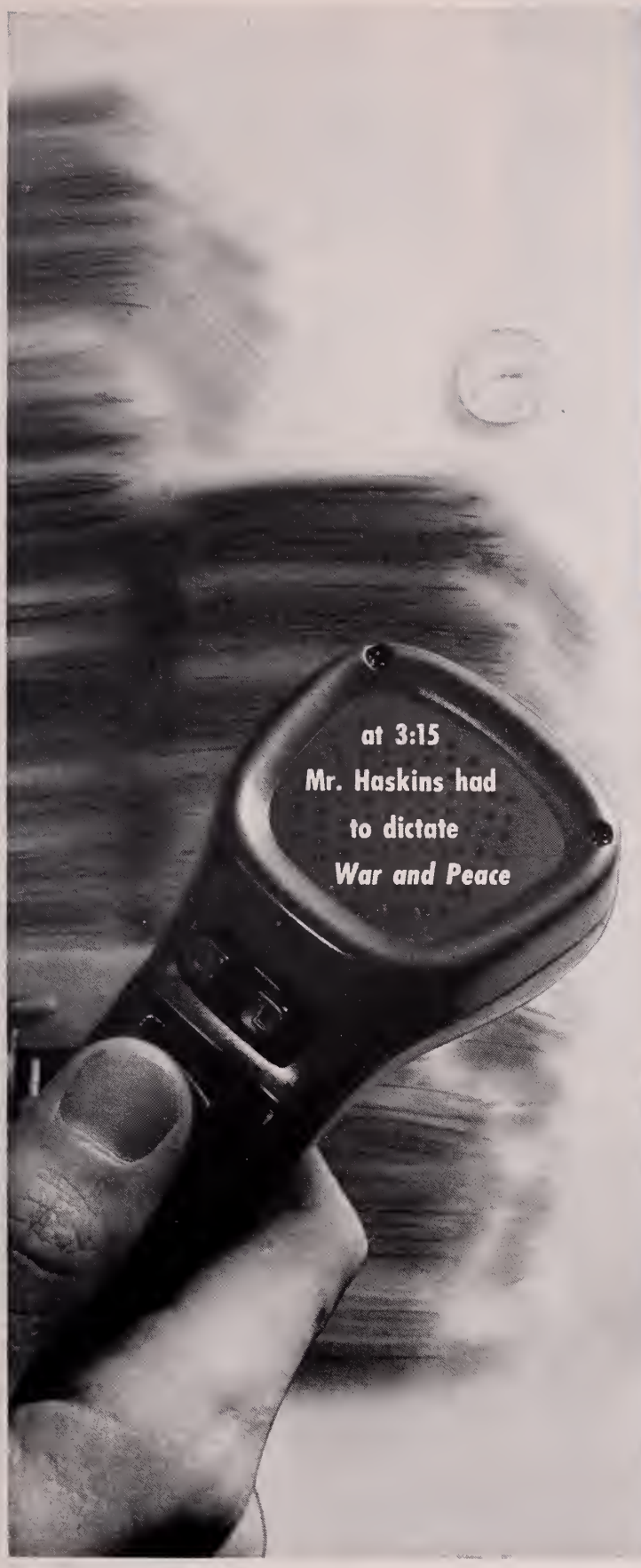
J. F. Wilkinson, M.D., 1962, 114 East Wisconsin Avenue, Oconomowoc

J. W. Nellen, M.D., 1959, 122 East Walnut Street, Green Bay

S. E. Gavin, M.D., 1961, 104 South Main Street, Fond du Lac

R. B. Larsen, M.D., 1958, 510½ Third Street, Wausau

(Continued on page 34)



To cut daytime lethargy

(and keep rauwolfia potency)

in treatment

of hypertension:

Additional clinical evidence[1] supports the view that HARMONYL offers full rauwolfia potency coupled with much less lethargy. In a new comparative study HARMONYL was given at the same dosage as reserpine and other rauwolfia alkaloids. Only one HARMONYL patient in 20 showed lethargy, while 11 patients in 20 showed lethargy with reserpine; 10 in 20 with the alseroxylon fraction.

Abbott

712291

for your hypertensives

who must stay on the job

Harmonyl*

while the drug works effectively . . .

so does the patient

*Trademark for Deserpidine, Abbott

1. Comparative Effects of Various Rauwolfia Alkaloids in Hypertension; *submitted for publication.*

NO WAITING

for

a

cumulative

response to

reserpine alone

in anxiety and hypertension

NEW *fast-acting*

filmtab

Harmonyl-N*

(Harmonyl* and Nembutal®)

Calmer days, more restful nights starting *first* day of treatment, through synergistic action of HARMONYL (Deserpidine, Abbott) and NEMBUTAL (Pentobarbital, Abbott). Lower therapeutic doses, lower incidence of side effects. Each HARMONYL-N Filmtab contains 30 mg. NEMBUTAL Calcium and 0.25 mg. HARMONYL. Each HARMONYL-N *Half-Strength* Filmtab combines 15 mg. NEMBUTAL Calcium and 0.1 mg. HARMONYL. Abbott

® Filmtab—Film-sealed tablets, Abbott, pat. applied for

801060 *Trademark

(Continued from page 32)

Maurice Hardgrove, M.D., 1958, 208 East Wisconsin Avenue, Milwaukee

H. E. Oppert, M.D., 1959, 318 South Main Street, Viroqua

E. J. Nordby, M.D., 1960, 2715 Marshall Court, Madison

L. W. Schrank, M.D., 1961, 200 East Main Street, Waupun

J. H. Wishart, M.D., 1962, 314 East Grand Avenue, Eau Claire

President, ex officio

Secretary, ex officio

Council on Medical Services

J. S. Devitt, M.D., 1958, chairman, 944 North Jackson Street, Milwaukee

D. E. Dorchester, M.D., 1960, 10 North Third Avenue, Sturgeon Bay

E. C. Cary, M.D., 1959. Reedsville

J. F. Maser, M.D., 1959, Rice Lake

C. J. Picard, M.D., 1959, 425 21st Avenue, Superior

R. L. MacCornack, M.D., 1960, Whitehall

H. J. Kief, M.D., 1960, 104 South Main Street, Fond du Lac

D. M. Willison, M.D., 1958, 314 East Grand Avenue, Eau Claire

W. J. Fencil, M.D., 1958, The Monroe Clinic, Monroe

Committee on Public Policy

A. A. Quisling, M.D., 1961, chairman, 2 West Gorham Street, Madison

J. M. Sullivan, M.D., 1962, 161 West Wisconsin Avenue, Milwaukee

J. R. Schroder, M.D., 1958, 500 West Milwaukee Street, Janesville

J. P. Conway, M.D., 1959, 1800 East Capitol Drive, Milwaukee

S. E. Gavin, M.D., 1960, 104 South Main Street, Fond du Lac

Earl C. Quackenbush, M.D., 1962, 14 North Main Street, Hartford

Robert G. Zach, M.D., 1962, 810 19th Avenue, Monroe

President, ex officio

President-elect, ex officio

Secretary, ex officio

(Continued on page 36)

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ACHROMYCIN ® Tetracycline	125 mg.
Phenacetin	120 mg.
Caffeine	30 mg.
Salicylamide	150 mg.
Chlorothen Citrate	25 mg.

Bottle of 24 tablets

syrup

Each teaspoonful (5 cc.) contains:

ACHROMYCIN ® Tetracycline equivalent to tetracycline HCl	125 mg.
Phenacetin	120 mg.
Salicylamide	150 mg.
Ascorbic Acid (C)	25 mg.
Pyrilamine Maleate	15 mg.
Methylparaben	4 mg.
Propylparaben	1 mg.

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(Continued from page 34)

Council on Scientific Work

L. G. Kindschi, M.D., 1958, chairman, The Monroe Clinic, Monroe

K. E. Lemmer, M.D., 1959, 1300 University Avenue, Madison

M. F. Huth, M.D., 1960, 203 Fourth Street, Baraboo

R. B. Larsen, M.D., 1962, 510½ Third Street, Wausau

M. C. F. Lindert, M.D., 1961, 161 West Wisconsin Avenue, Milwaukee

R. S. Baldwin, M.D., 650 South Central Avenue, Marshfield

J. S. Hirschboeck, M.D., 561 North Fifteenth Street, Milwaukee

John Z. Bowers, M.D., 1300 University Avenue, Madison

Special Committee of the President on Veteran Affairs

F. L. Weston, M.D., chairman, 1 South Pinckney, Madison

J. P. Conway, M.D., 1800 East Capitol Drive, Milwaukee

S. W. Hollenbeck, M.D., 2650 West Fond du Lac Avenue, Milwaukee

C. E. Koepp, M.D., Marinette Medical Clinic, Marinette

F. H. Wolf, M.D., 419–421 Main Street, La Crosse

R. E. Galasinski, M.D., 3333 South 27th Street, Milwaukee, ex officio

President, ex officio

President-elect, ex officio

Council Committees

Appointments to the following committees are made by the chairman of the Council at the time of the Annual Meeting in May.

Committees of the Council (composed of members of Council):

- Economic Medicine
- Executive
- Finance
- Planning
- Scientific Medicine

Council Committees:

- Blood Bank
- Civil Defense
- Commission on Medical Care Plans
- Commission on State Departments
- Diabetes
- Editorial Board
- Division of Surgical Fees
- Military Medical Service

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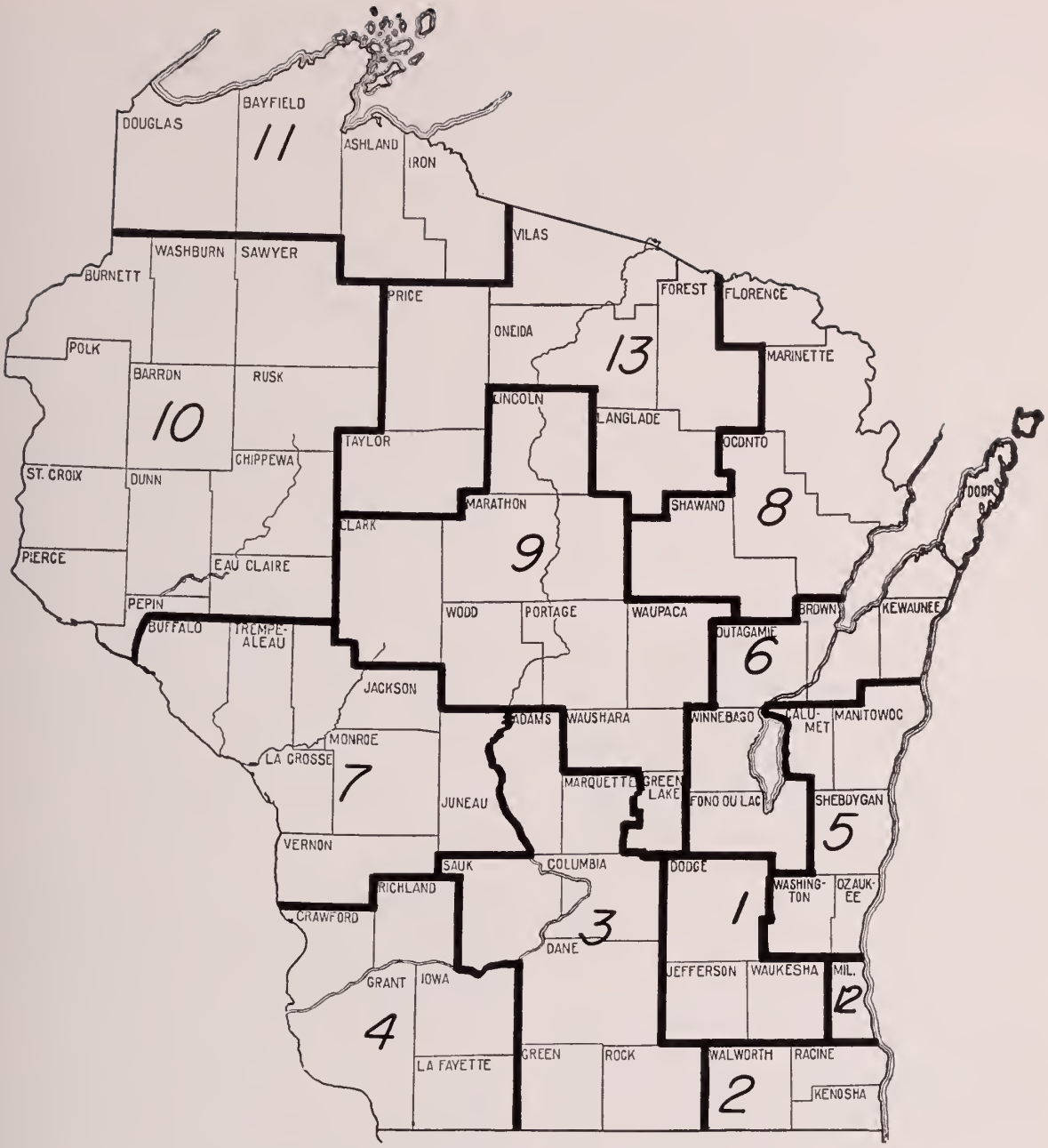

MAP INDICATING LOCATION OF COUNCILOR DISTRICTS

First District:
Dr. W. D. James, Oconomowoc

Second District:
Dr. L. H. Lokvam, Kenosha

Third District:
Dr. N. A. Hill, Madison
Dr. J. H. Houghton, Wisconsin Dells

Fourth District:
Dr. E. M. Dessloch, Prairie du Chien

Fifth District:
Dr. A. H. Heidner, West Bend

Sixth District:
Dr. G. W. Carlson, Appleton

Seventh District:
Dr. J. C. Fox, La Crosse

Eighth District:
Dr. J. M. Bell, Marinette

Ninth District:
Dr. R. E. Garrison, Wisconsin Rapids

Tenth District:
Dr. R. G. Arveson, Chairman, Frederic

Eleventh District:
Dr. V. E. Ekblad, Superior

Twelfth District:
Dr. R. E. Galasinski, Milwaukee
Dr. E. L. Bernhart, Milwaukee
Dr. G. S. Kilkenny, Milwaukee
Dr. J. P. Conway, Milwaukee
Dr. J. E. Conley, Milwaukee

Thirteenth District:
Dr. J. D. Leahy, Park Falls

Dr. S. E. Gavin, Chairman Emeritus, Fond du Lac

Charter Law of Medical Societies in Wisconsin

Chapter 148

148.01 (1) State society. The state medical society of Wisconsin is continued with the general powers of a corporation. It may from time to time adopt, alter and enforce constitution, by-laws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

(3) (a) The state society, or a county society in manner approved by the state society, shall have the power to establish in the state or in any county or counties therein, a nonprofit plan or plans for the sickness care of indigents and low income groups, and others, through contracts with public officials, and with physicians and others, and by the use of contributions, cooperative funds, and other means, provided only that free choice of physicians within such contracts shall be retained and that responsibility of physicians to patient and all other contract and tort relationships with patient shall remain as though the dealings were direct between physician and patient. Any person covered by or insured under such plan shall be free to choose for sickness care any medical or osteopathic physician, licensed to practice in Wisconsin who has agreed to abide by such plan according to its terms and no such physician or osteopath shall be required to participate exclusively in any such plan.

(b) Such plan shall be exempt from the state insurance laws except those provisions relating to nondiscriminatory rates contained in section 201.53, investments contained in section 201.25 and premium reserves contained in section 201.18 (1).

(c) The society shall file with the commissioner of insurance a written declaration defining the organization and structure of the proposed sickness care plan and its area of operations and shall file any amendments or changes thereto. There shall also be filed with the commissioner specimen copies of all contracts with the insured and with the participating physicians and surgeons and the form of such contracts must be approved by the commissioner.

(d) The provisions of section 148.01 (3) (c) shall not apply to any plan nor to any revisions thereof in existence on the effective date of this paragraph, nor to any contracts for the care of the indigent, nor shall any provision of chapter 148 be construed to apply to any corporation, association or organization not a body corporate under said chapter.

148.02 (1) County societies. The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the state board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than fifteen adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, by-laws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, by-laws and regulations of the state society.

1841—THE SOCIETY CREATED BY TERRITORIAL LEGISLATION

The first statutory recognition of the State Medical Society was by act of the Legislative Assembly of the Territory of Wisconsin, in Act 53 of the Territorial Legislature of 1841. The organization of the Society was authorized, with the declaration that ". . . well regulated medical societies have been found to contribute to the advancement and diffusion of true science, and particularly of the healing art. . ."

The organization meeting was set for the second Monday in January, 1842, at Madison, for the purpose of forming ". . . a society under the name and style of the Medical Society of the Territory of Wisconsin. . ." Drs. Bushnell B. Cary, M. C. Darling, Lucius I. Barber, Oliver E. Strong, Edward McSherry, E. W. Wolcott, J. C. Mills, David Walker, Horace White, Jonas P. Russell, David Ward, Jesse S. Hewett, B. O. Miller, and their associates, were authorized by statute to conduct the initial organization of the Society.

Constitution and By-Laws of the State Medical Society of Wisconsin*

CONSTITUTION

ARTICLE I

NAME OF THE ASSOCIATION

The name and title of this organization shall be the State Medical Society of Wisconsin.

ARTICLE II

PURPOSE

The purposes of this Society shall be to federate and bring into one compact organization the entire medical profession of the State of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III

COMPONENT SOCIETIES

SECTION 1. Component societies shall consist of those county medical societies which hold charters from this Society.

SEC. 2. The terms, county medical society and component county medical society, shall be deemed to include all county medical societies and academies of medicine now in affiliation with this Society, or which may hereafter be organized and chartered by the House of Delegates of this Society.

ARTICLE IV

COMPOSITION OF THE ASSOCIATION

SECTION 1. This Society shall consist of members who shall be the members of the component county medical societies, and, who shall also be members in good standing of the American Medical Association, and who have been certified to the headquarters of this Society, and all of whose dues and assessments for the current year have been received by the secretary.

SEC. 2. Those members who have been elected to honorary membership by the various component county societies may be enrolled as honorary members of this Society upon approval of the Council. These honorary members shall enjoy all the rights of membership, and their dues to the State Society shall be remitted.

SEC. 3. Members in good standing who shall make outright gifts to the Endowment Fund of this Society, in the amount of $1,000 or more, shall have bestowed upon them the gift of life membership in this Society. Such membership shall carry with it all the perquisites of active membership, without the requirement of annual dues, and shall continue in force during the life of the member, providing that the member continues in good standing in his local county medical society.

ARTICLE V

HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of the Society, and shall consist (1) of delegates elected by the component county medical societies, and one delegate representing each Section of the Society organized under the By-Laws and (2) the officers of the Society enumerated in Section 1 of Article IX of this Constitution, and past presidents of the Society shall be ex officio members, but without the right to vote.

ARTICLE VI

COUNCIL

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and By-Laws. It shall consist of the councilors and the immediate past president. The president, the president-elect, the secretary, the treasurer and the speaker of the House of Delegates shall be ex officio members of the Council, but without the right to vote. Nine of its members shall constitute a quorum.

ARTICLE VII

SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections, and for the organization of such councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies.

ARTICLE VIII

SESSIONS AND MEETINGS

SECTION 1. The Society shall hold an annual session during which there shall be at least two general meetings, open to all registered members, delegates and guests.

SEC. 2. The place for holding each annual session shall be fixed by the House of Delegates, or, by failure to act, such authority is delegated to the Council. The time for holding each annual session shall be approved by the Council.

SEC. 3. Special meetings of either the Society or the House of Delegates may be called by a two-thirds vote of the Council or upon petition by twenty delegates.

* As amended by the 1957 House of Delegates.

ARTICLE IX

OFFICERS

SECTION 1. The officers of this Society shall be a president, a president-elect, a secretary, a treasurer, councilors from thirteen districts, and a speaker and vice speaker of the House of Delegates.

Each councilor shall be nominated only by the elected delegates of the county medical society or societies in the district for which he is nominated.

SEC. 2. The officers, except the councilors, shall be elected annually. The terms of the councilors shall be for three years. There shall be elected one councilor for each of the thirteen districts, except that in any councilor district embracing a membership of 250 or more, there shall be elected one additional councilor for each additional 250 members or major fraction thereof.

As nearly as possible, one third of the members of the Council shall be elected each year. The secretary and the treasurer shall be elected by the Council. All these officers shall serve until their successors are elected and installed.

The president-elect shall automatically succeed the office of president at the conclusion of his one-year term of president-elect.

ARTICLE X

FUNDS AND EXPENSES

SECTION 1. Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. The treasurer and secretary shall submit an annual budget to the Council. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

SEC. 2. The House of Delegates, by adoption of a by-law, may provide for a special classification of members at per capita reduced dues where such classification may be applied generally throughout the state, and has no special application to individual members or to individual societies.

ARTICLE XI

REFERENDUM

At any general meeting of the Society it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Society for its vote. A majority vote of all the members of the Society shall determine the question.

ARTICLE XII

SEAL

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII

AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in the bulletin or Journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.

BY-LAWS

CHAPTER I

MEMBERSHIP

SECTION 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of his county society shall be *prima facie* evidence of membership and of his right to register at the annual session.

SEC. 2. No person who is under sentence of suspension or expulsion from any component society of this Society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Society.

SEC. 3. Each member in attendance at the annual session shall register, when his right to membership has been verified by reference to the records of this Society. No member shall take part in any of the proceedings of the annual session until he has complied with the provisions of this section of the By-Laws.

CHAPTER II

GENERAL MEETINGS

SECTION 1. The general meetings shall be open to all registered members and guests. At such time as may have been arranged, shall be delivered the annual addresses of the president and of the president-elect.

SEC. 2. The Council shall establish rules relating to requiring written papers of speakers. All papers read before this Society shall be its property. Each paper, when it has been read, shall be deposited with the secretary. Authors of papers read before this Society shall not cause them to be published elsewhere until after they have been published in its Journal or returned by the Editorial Board. Authors who fail to observe this section shall be ineligible to appear on programs of the State Society for a period of five years.

CHAPTER III

HOUSE OF DELEGATES

SECTION 1. The House of Delegates shall meet annually at the time and place of the annual session.

SEC. 2. Each component county society shall be entitled to send each year one delegate or one corresponding alternate to the House of Delegates for each fifty full-paid members or major fraction thereof in this Society provided, however, that each county society shall be entitled to at least one delegate or one corresponding alternate.

The term "full-paid members," as used in this section, includes regular members of the Society,

life members, affiliate members, associate members, educational members, and members whose dues are waived or remitted by official action of the Society. Special service members, resident members, partial-pay members, and members who are delinquent in dues payments shall not be included in the term "full-paid members."

For purposes of this section, the number of fully paid members as of the close of the calendar year preceding the first session of the House of Delegates at the annual meeting shall determine the number of delegates to which a county medical society may be entitled.

The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society at least thirty days before the annual session. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 3. One-fourth of the members of the House of Delegates registered, representing one-fourth of the county medical societies in the state, shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

SEC. 4. From among members of the House of Delegates, the speaker of the House of Delegates, for the purpose of expediting proceedings, shall appoint Reference Committees to which reports and resolutions shall be referred as follows:

a. On Credentials.
b. On Resolutions.
c. On Reports of Officers.
d. On Reports of Standing Committees.

He shall also appoint such other committees as may be considered by him to be necessary.

SEC. 5. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body.

SEC. 6. The House of Delegates shall divide the state into councilor districts, specifying what counties each district shall include, and, when the best interest of the Society and the profession will be promoted thereby, organize in each a district medical society, of which all members of the component county societies shall be members.

SEC. 7. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.

SEC. 8. It shall approve all memorials and resolutions issued in the name of the Society before they shall become effective.

SEC. 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society twenty days before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Council, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

CHAPTER IV

ELECTION OF OFFICERS

SECTION 1. The House of Delegates at its first meeting at the annual session shall elect a Committee on Nominations consisting of one delegate from each councilor district. The Committee on Nominations shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each of the offices to be filled at that annual session. No two candidates for president-elect shall be from the same district. Each candidate for councilor must be a resident of the district for which he is nominated. Nominations for councilor shall be made from the floor and not from the Committee on Nominations.

SEC. 2. The report of the nominating committee and the election of officers shall be the first order of business of the House of Delegates at the third meeting of the House.

SEC. 3. All elections of officers, where more than one nomination is received, shall be by ballot and a majority of the votes cast shall be necessary to elect except for delegates and alternates to the American Medical Association. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when he shall be declared elected. In case no delegates or alternates for the American Medical Association receive on the first ballot a majority of the vote, the nominees shall be declared elected in the order of the highest number of votes received, until the allotted number shall have been chosen. In case of a tie vote for delegate or alternate, the tie shall be determined by lot.

SEC. 4. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

SEC. 5. No person known to have solicited votes for or sought any office within the gift of this Society shall be eligible for any office for two years.

CHAPTER V

DUTIES OF OFFICERS

SECTION 1. The president shall preside at all meetings of the Society; he shall appoint a Committee on Arrangements for the annual session and all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the state and assist the councilors in building up the county societies, and in making their work more practical and useful.

SEC. 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect the Council shall appoint one of its mem-

bers as acting president until the next meeting of the House of Delegates.

SEC. 3. The treasurer shall give bond in such amount as the Council may provide. He shall demand and receive all funds due the Society, together with bequests and donations. He shall pay money out of the treasury only on a written order of the secretary; he shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his doings and of the state of the funds in his hands.

SEC. 4. The secretary shall attend the general meetings of the Society and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be secretary of the Council. He shall be custodian of all record books and papers belonging to the Society, except such as properly belong to the treasurer, and shall keep account of and promptly turn over to the treasurer all funds of the Society which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card index register of all the legal practitioners of the state by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. He shall supply all component societies with the necessary blanks for making their annual reports, and shall collect from them the regular per capita assessments and turn the same over to the treasurer. The amount of his salary shall be fixed by the Council.

The secretary shall maintain certified copies of each component county society's constitution and by-laws, together with any amendments to the same.

SEC. 5. The speaker shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

SEC. 6. The vice-speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice-speaker shall officiate during the unexpired term.

CHAPTER VI

COUNCIL

SECTION 1. The Council shall meet on the day preceding the annual session, and daily *if necessary* during the session and at such other times as necessity *may* require, subject to the call of the chairman or on petition of three councilors. It shall hold an annual meeting, for purposes of organization and other business. Its chairman shall make an annual report to the House of Delegates.

SEC. 2. Each councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of and to aid in the betterment of the component societies of his district. Each councilor shall arrange for an annual conference with the societies within his councilor district, either through individual meetings or district meetings, at which time information shall be brought concerning activities of the State Medical Society and component societies within the district. He shall make an annual report of his work, and of the condition of the profession of each county in his district at the annual session of the Council. The necessary traveling expenses incurred by each councilor in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include his expense in attending the annual session of the Society.

SEC. 3. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the power conferred on the House of Delegates by the Constitution and By-Laws.

The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component societies, on which an appeal is taken. Its decision in all cases, including questions regarding membership in this Society, shall be final.

SEC. 4. Charters shall be issued to county societies only on approval of the Council, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws.

SEC. 5. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

SEC. 6. The Council shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have authority to appoint an editor of the Journal and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee shall audit all accounts of this Society, and with the treasurer, supervise the investment of funds. The Council shall adopt an annual budget providing for the necessary expenses of the Society, which shall be prepared and presented for its consideration by the treasurer and secretary at the first meeting of the Council in January of each year. Its chairman shall submit an annual report to the House of Delegates, which shall specify the character and cost of the publications of the Society, the amount and character of all of its property, and shall provide full information concerning the management of all affairs of the Society which the Council is charged to administer.

SEC. 7. The Council shall, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified.

SEC. 8. The Council may elect as secretary one who need not be a physician nor a member of the Society.

SEC. 9. The salaries of all employees of the Society shall be fixed by the Council.

SEC. 10. The Council shall provide such headquarters for the Society as may be required to conduct its business properly.

CHAPTER VII

COMMITTEES

SECTION 1. The standing committees of this Society shall be as follows:

- A Council on Scientific Work.
- A Council on Medical Service.
- A Committee on Public Policy.
- A Committee on Grievances.
- A Committee on Medical Education and Hospitals.
- A Committee Advisory to the Woman's Auxiliary.
- A Committee on Hospital Relations.
- A Committee on Cancer.

Unless otherwise provided in these By-laws, each of these committees shall consist of five members, each of whom shall serve for a term of five years. One member of each of these committees shall be appointed annually by the incoming president, by and with the consent of the House of Delegates, provided that where the House creates a new standing committee the original appointments shall be for terms of one, two, three, four, and five years, and thereafter for terms of five years each.

SEC. 2. The Council on Scientific Work shall consist of five *appointed* members and the deans of the two medical schools in Wisconsin and the medical editor of the Wisconsin Medical Journal. Each appointed member shall serve for a period of five years. The Council on Scientific Work shall study the character and scope of the scientific proceedings of the Society and shall prepare the scientific program for the annual meeting. It shall likewise study the field of postgraduate education, making available, so far as lies within its power, program material for such postgraduate education both through programs of component societies and in such other ways as it may find feasible. It shall also be in charge of the affairs of the Journal. Important questions of editorial policy shall be submitted to the Council of the Society and an annual report shall be made to the House of Delegates.

SEC. 3. The Council on Medical Service shall consist of nine members appointed by the president of the Society. Appointments shall be so made that the terms of one-third of the members expire each year. The Council on Medical Service shall act to correlate activities of the Society in medical economic fields, and to inform the profession and the public of proposed changes affecting medical care in the state and the nation. It shall likewise study and suggest means for the improvement of the distribution of medical service to the public, and shall periodically inform county medical societies regarding its activities.

The Council shall direct the program of the Society in the field of public health education, and in such manner as is found suitable, shall seek to further the health of those employed in Wisconsin industry, as well as to promote the health and safety of those engaged in rural Wisconsin.

SEC. 4. The Committee on Public Policy shall consist of seven members, and the president, the president-elect and secretary. The committee shall present to those public officers charged with the duty of enacting or enforcing measures in the interest of public health, all available information that may in any way assist such officers honorably to discharge their responsibilities.

SEC. 5. The Committee on Grievances shall investigate all reported claims against members for compensation for injuries said to have resulted from malpractice. It shall determine as nearly as may be practicable the circumstances leading up to the making of the claim itself and the grounds on which the claim is based. The committee shall recommend to the Society from time to time such measures as it deems practicable for the limitation or removal of the causes of such claims. It may, at the request of any member against whom a claim has been made, place at his disposal such evidence as becomes available to the committee. If the committee believes a claim unjust, it shall, at the request of the member against whom the claim has been made, cooperate, so far as it can lawfully do so, with him and his counsel in defense against it. If the committee believes that the claim that it has investigated is a just claim, the committee may, at the request of the member against whom the claim was made, cooperate with him and his counsel, so far as it lawfully can do so, in effecting an equitable settlement. The committee shall submit a report of its proceedings at each annual meeting of the Society, covering the preceding year, in which report shall be included all recommendations made by the committee during the year looking toward the removal of the causes of claims based on alleged malpractice. The committee shall possess similar responsibilities where request is made to investigate complaints bearing upon a member's alleged violation of any provision of the Medical Practice Act.

The committee shall consist of nine members and the terms of one-third of its members shall expire each year, with each member appointed for a term of three years.

SEC. 6. The Committee on Medical Education and Hospitals shall serve in this state for the Council on Medical Education and Hospitals of the American Medical Association, and shall have referred to it all questions pertaining to hospitals and medical education.

The deans of the two Medical Schools in Wisconsin shall be members of this Committee, in addition to those appointed annually.

SEC. 7. The Committee Advisory to the Woman's Auxiliary shall consist of the chairman of the Council, the immediate past president, the president, the president-elect, and the secretary. Its principal duties shall be to advise state officers of the Auxiliary, particularly in the field of approval of new projects.

SEC. 8. The Committee on Hospital Relations shall consist of six members, and each member shall serve for a period of three years. Of the original appointments, two members shall be appointed for a term of one year, two members for a term of two years, and two members for a term of three years, and thereafter for terms of three years each. The principal duty of this committee shall be to consider, investigate and study the interrelationship of the medical profession to the hospital institutions, and to act in an advisory capacity to the Society.

The Committee on Hospital Relations of the State Medical Society of Wisconsin is specifically charged with the responsibility of receiving and considering all complaints and/or queries from any physician, hospital, medical organization, or other interested person or group, relating to professional and/or economic problems occurring in the practice of medicine in hospitals wherein a dispute has arisen be-

tween a physician and a hospital. If the matter under consideration cannot be arbitrated by the good offices of the Committee on Hospital Relations, its findings to that effect shall be transmitted to the Council of the State Medical Society of Wisconsin with its findings and recommendations in order that the Council may then make suitable recommendations to the Judicial Council of the American Medical Association.

SEC. 9. The Committee on Cancer shall consist of a member appointed from each of the councilor districts of the State Society, and its principal duties shall be advisory to the Society and cooperating agencies as to those means best designed to aid in the prevention and alleviation of cancer. As nearly as possible, the terms of one-third of the members of the committee shall expire each year, with each committee member being appointed for a term of three years.

SEC. 10. The Wisconsin Medical Journal shall be the official Journal of the Society.

CHAPTER VIII

DUES AND ASSESSMENTS

SECTION 1. The annual dues and assessments shall be determined by the House of Delegates, and shall be levied per capita on the members of the Society. They shall be payable on or before January 1 of the year for which they are levied. The secretary of each component society shall cause to be collected and shall forward to the offices of the Society the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before March 31 shall stand suspended until his name is properly reported and his dues for the current year properly remitted.

An active member in good standing in his county society who has for thirty-five continuous years been a member of this State Society shall receive a special certificate and plaque indicating the completion of such period of membership.

SEC. 2. *Life Membership.* An active member who shall have been a member of his county and state medical societies in Wisconsin continuously for fifty consecutive years shall be offered the status of a life member, and if he accepts shall enjoy full membership privileges, but shall be exempt from the payment of dues or assessments. He shall receive a certificate of life membership.

SEC. 3. *Affiliate Membership.* An active member in good standing in his county society may, upon the recommendation of the secretary and president of the county medical society and with approval of the State Medical Society, be granted affiliate membership with full voting and other privileges. Such membership shall be on an annual basis only, and shall be granted where such member suffers a physical or other disability preventing the practice of medicine with resulting serious financial reverses that would make payment of dues a matter of personal hardship.

SEC. 4. *Associate Membership.* A member in good standing in his county society, who has retired completely from the practice of medicine, may apply for associate membership. With approval of his county society and of the Council, such membership shall be granted on payment of $10 annual dues.

SEC. 5. *Educational Memberships:* Physicians engaged solely in educational and research activities, and no part of whose income is derived from the private practice of medicine, shall be eligible to full membership in this Society, with all the privileges and responsibilities of membership, upon the payment of annual dues equal to approximately 75 per cent of that annually determined for full dues-paying members. Such members shall be issued a certificate denoting such special membership, and the content shall be approved by the Council. Application for such membership shall be endorsed by the chief of service or other physician in supervision.

SEC. 6. The record of payment of dues and assessments on file in the offices of the Society shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Society and of the House of Delegates.

SEC. 7. Any county society which fails to make the reports required, at least thirty days before the annual session of the State Society, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Society or of the House of Delegates.

CHAPTER IX

The ethical principles governing the members of the American Medical Association shall govern members of this Society. No member shall profess adherence or give support to any exclusive dogma, sect or school.

CHAPTER X

The deliberations of this Society, except as may be provided otherwise in the Constitution and By-Laws, shall be conducted in accordance with parliamentary usage as defined in Roberts' Rules of Order.

CHAPTER XI

SECTION 1. All county societies now in affiliation with the State Society or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and By-Laws shall, upon application to the Council, receive charters from this Society, provided that their constitutions and by-laws shall have been submitted to the Council and received its approval.

SEC. 2. Only one component medical society shall be chartered in each county.

SEC. 3. Each county society shall judge of the qualifications of its members, subject to review and final decision by the Council of the State Society. Every reputable and legally qualified physician who is a bona-fide resident of the same county shall be eligible to apply for membership so long as he does not practice nor profess to practice sectarian medicine, or engage in practice in a manner in conflict with the Principles of Ethics of the American Medical Association, or so conduct himself as to defeat the purposes for which the Society is organized and is operating. By proper provision of constitution and by-laws, either or both as may be necessary, the county society may require of an applicant for membership that he shall have resided within the jurisdiction of the society to which he is applying, for a period of one year as a condition precedent to election to membership; or the county society may provide that an applicant for membership first may be elected to membership for a term of only one year, with the provision that such membership shall then terminate, and the member resubmit to election, without limitation as to term, by vote of the society.

A member of a component society whose license has been revoked or suspended shall be dropped from membership automatically as of the date of revocation or suspension. The Council of the State Society shall have final authority to expel a member should a component county society fail to do so after being so requested by the Council.

A physician living near a county line may hold his membership in that county most convenient for him to attend, on permission of the component society in whose jurisdiction he resides.

A member who removes his principal practice from within the territorial limits of a county medical society in which he shall hold membership, shall not be eligible to continue his membership in such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to apply for membership anew or by transfer to the society in whose jurisdiction his principal practice shall have been removed.

By proper provision of Constitution and By-Laws, either or both as may be necessary, a county society may admit to membership those in training as hospital residents or as research fellows who are licensed to practice medicine and surgery in the state of Wisconsin, upon the payment of dues not to exceed $5 annually, of which at least $3 shall be remitted to the State Society, provided that any applicant so elected shall not be permitted such membership beyond a period of five years from the date of such election, and shall not be included as a "fully paid" member as that term is used in Section 2 of Chapter III.

SEC. 4. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Council, whose decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Council of the State Society for final determination. The period of time within which appeal to the Council may be taken shall be limited to six months following the date of decision by the constituted authority of a component county medical society.

SEC. 5. In hearing appeals the Council may admit oral or written evidence as in its judgment will most fairly present the facts, but in the case of every appeal both as a board and as individuals, the councilors shall, preceding all such hearings, make efforts at conciliation and compromise.

SEC. 6. When a member in good standing in a component county society moves to another county in this state, he shall be given a written certificate of these facts by the secretary of his society, without cost, for transmission to the secretary of the society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he removes, such member shall be considered to be in good standing in the county society from which he was certified and in the State Society to the end of the period (respectively) for which his dues have been paid.

SEC. 7. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

SEC. 8. Each component county society shall elect one or more delegates and an equal number of individual alternates therefor to represent it in the House of Delegates of this Society, in accordance with Chapter III, Section 2, of these By-Laws. The term of office shall be pursuant to the constitution and by-laws of the county medical society but shall begin on January 1 of the year succeeding the election of such delegate. The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society at least thirty days before the annual session. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 9. The secretary of each county society shall keep a roster of its members, and, if practicable, a list of nonaffiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary by Council. He shall send a copy of the program of each county meeting to his district councilor and to the secretary.

SEC. 10. Each county society shall appoint or elect one or more of its members as a member of an auxiliary Committee on Public Policy, and the county society secretary shall send his name and address at once to the secretary of this Society. The Committee on Public Policy of this Society shall formulate the duties of this auxiliary committee and supply each member with a copy. The auxiliary committeemen shall be accountable to their county societies and to the Council for prompt response to and continued cooperation with the Committee on Public Policy of this Society.

SEC. 11. This Society shall recognize as a special service member any physician who is in the armed forces of the United States, who has been licensed to practice medicine and surgery in Wisconsin, and who has not previously been a member of any county medical society. Such physician shall first have been accepted as a special service member by a component county society in accordance with the provisions of its constitution and by-laws, and the fact of such membership certified to this Society. Application for such special service membership shall not be dependent upon the place of previous residence or the place or period of previous practice, and such membership shall include all the rights and privileges of active membership excepting those of voting and holding office.

No dues shall be assessed against such member until the month following his discharge from the armed forces of the United States, at which time he shall pay prorated dues for the balance of the calendar year of his discharge from service. Special service membership shall lapse at the close of the calendar year of the discharge of each such member from service.

CHAPTER XII

SECTION ON MEDICAL HISTORY

Membership in this Section shall be composed of those interested in preserving medical history in Wisconsin. The Section shall have the power to elect its chairman and other officers, and the office of the secretary of the State Medical Society shall provide secretarial assistance to it.

Annual dues shall be fixed by the Section and shall not exceed $10 per year. The Section is empowered to accept contributions to its projects and may solicit funds in behalf of the Society. All funds of the Section shall be segregated, and expenditures from them shall be made under direction and supervision of the Section, subject to approval of the Council.

Special membership certificates may be issued to those who become members of the Section, and dis-

plays may be developed by the Section for exhibit at the Society's Annual Meeting and elsewhere.

CHAPTER XIII

SCIENTIFIC SECTIONS

SECTION 1. The House of Delegates shall, if so recommended by the Council from time to time, establish such scientific sections within the Society as it may determine and shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

SEC. 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest, but qualifications for membership in any section may be prescribed by the members of such section, subject only to approval of the Council, except that scientific meetings of the section shall be open to all members in good standing of the State Medical Society.

SEC. 3. The officers of any such section shall be those prescribed by the members thereof. The terms of such officers shall be for the term of one year, but any officer may be reelected.

SEC. 4. The officers of any such section shall constitute the executive committee thereof, and a majority of the executive committee must vote with the majority of the members in order for any action of the section to be effective. The executive committee shall have the power to appoint such committees within a section as it deems necessary from time to time.

SEC. 5. No section shall have the power to bind the Society by any resolution or other action, or to publicize the same, unless the same shall first be approved by the House of Delegates, or by a majority of the members of the Council when the House of Delegates is not in session. No resolution adopted by any section shall be effective until likewise so approved.

SEC. 6. Each section so established shall have the privilege of electing a delegate and alternate to the House of Delegates.

CHAPTER XIV

SECTION 1. These By-Laws may be amended at any annual session by a majority vote of the delegates present at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid over for one day.

SEC. 2. Upon the adoption of this Constitution and these By-Laws, all previous Constitutions and By-Laws are thereby repealed.

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ANNUAL MEETING

MILWAUKEE **MAY 6-7-8, 1958**

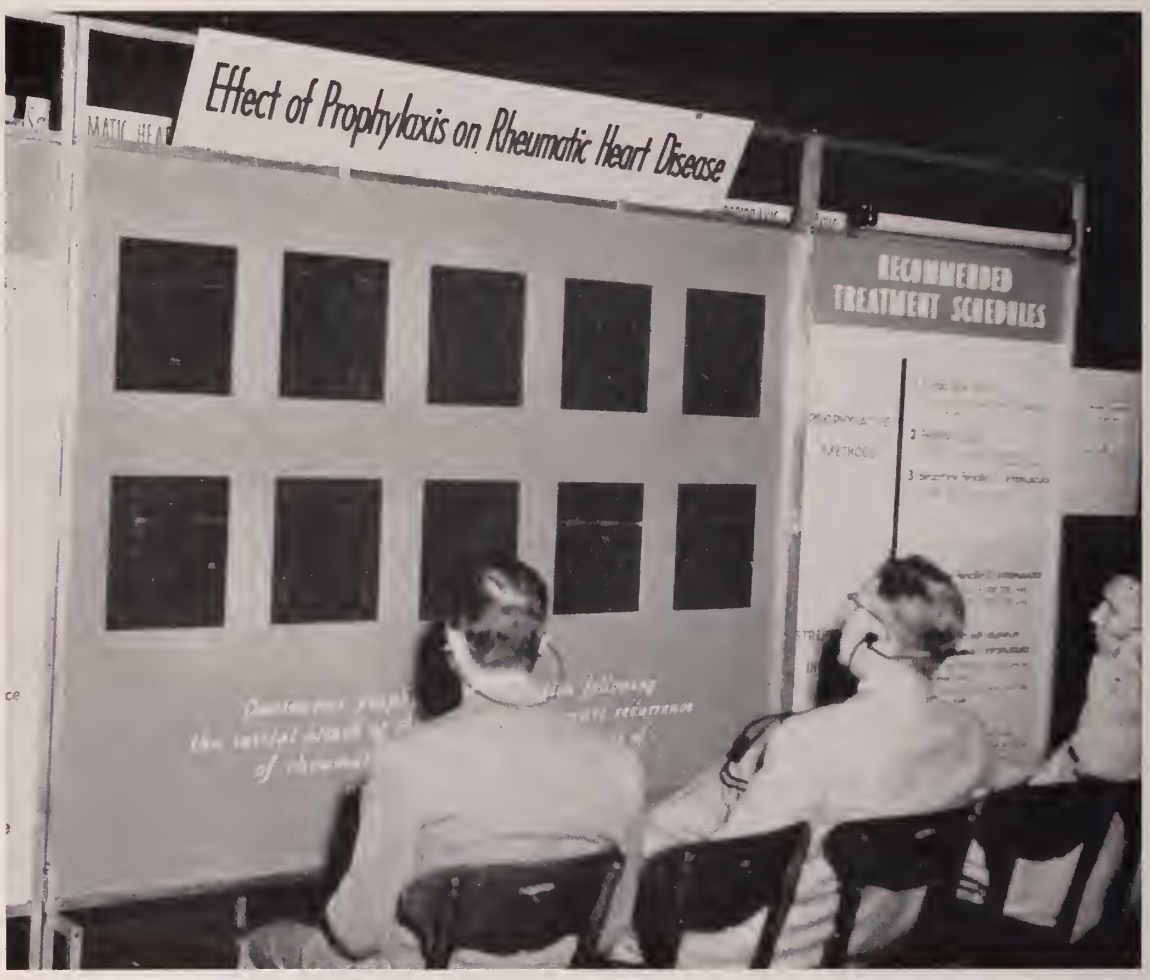
HOUSE OF DELEGATES

It is a privilege as well as an opportunity for any member of the State Medical Society to appear before the reference committees of the House of Delegates and present his views on any matter properly before them. Any member, whether he wishes to appear before the committees or merely to listen in on their deliberations, is urged to participate in this all-important aspect of Society activities.

. . . EAST ROOM, HOTEL SCHROEDER . . .

ANNUAL MEETING

MILWAUKEE **MAY 6-7-8, 1958**



SCIENTIFIC PROGRAM . . . . . MILWAUKEE AUDITORIUM

MAY 6

GENERAL PRACTICE DAY—Oral Preparations for Diabetes, Athletic Stress, Fractures, Behavior Disturbances, Placebos and Tranquilizers, Office Gynecology, and Cancer Detection

MAY 7

Cancer Symposium and Special Programs on Internal Medicine, Radiology, Obstetrics and Gynecology, Psychiatry, and Surgery

MAY 8

Special Programs on Gastroenterology, Anesthesia, Pediatrics, Otolaryngology and Ophthalmology, and Surgery

ANNUAL MEETING

MILWAUKEE **MAY 6-7-8, 1958**

ROUND-TABLE LUNCHEONS

Hotel Schroeder, May 6, 7, and 8. Subjects include: Carcinoma in Situ, Shoulder Fractures, Hazards of Anesthesia, Preventive Psychiatry in Children, Fetal Distress, Diabetic Care, Private Physician and Public Health, Medical Aspects of Current Athletic Picture, Management of Peritonitis in Infancy, Management of Common Skin Disease, New Therapy of Leukemia and Lymphomas.

OUTSTANDING SPEAKERS . . . PLAN TO ATTEND

ANNUAL MEETING

MILWAUKEE **MAY 6-7-8, 1958**

ANNUAL DINNER, WEDNESDAY MAY 7, AT 6:15 P. M.

The President's Reception, 50 Year Club, Outstanding Professional Entertainment, Good Fellowship and Fun.

CRYSTAL BALLROOM . . . HOTEL SCHROEDER

Members, State Medical Society of Wisconsin*

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Naylen, F. J.

Albany:
Bongiorno, F. J.

Algoma:
March, J. F.
Pudleiner, H. G.
Stiehl, C. W.

Allenton:
Fisher, R. S.

Alma:
Bachhuber, M. O.

Amery:
Cornwall, W. B.
Dasler, H. A.
Ford, K. K.
Marra, M. G.
Whitlark, F. L.

Amherst:
Oscka, S. R

Antigo:
Beattie, B. W.
Cromer, R. W.
Curran, W. P.
Dorzeski, E. F.
Garbisch, F. H.
Garritty, J. E.
Lambert, J. W.
McKenna, E. A.
Moore, G. E.

Appleton:
Adrians, W. A.
Anderson, J. G.
Benton, J. L.
Bolton, E. L.
Bonner, J. N.
Carlson, G. W.
Chandler, W. W.
Cunningham, P. M.
Curry, J. C.
Dafoe, W. A.
DeCock, R. D.
Erchul, J. W.
Felton, W. C.
Frawley, W. J.
French, G. A.
Gallaher, D. M., Jr.
Giffin, W. S.
Gmeiner, J. E.
Gross, H. T.
Hale, William H.
Hamel, H. H.
Harrington, Wm. J.
Hauch, F. M.
Haza, B. J.
Hegner, G. T.
Huberty, F. J.
Kagen, M. S.
Keane, K. M.
Kennedy, R. O.
Konz, S. A.
Krueger, E. N.
Laird, J. W.
Landis, R. V.
Loescher, T. M.
Luther, T. W.
MacLaren, J. B.
Marshall, F. S.
Marshall, V. F.
McBain, L. B.
Meyers, C. L.
Mielke, E. F.
Miller, E. J.
Neidhold, C. D.
Nichols, G. P.
Rankin, F. J.
Russell, J. H.
Savage, G. W.
Schumacher, D. R.
Siegrist, K. J.
Simenson, R. S.
Skibba, J. P.
Sullivan, J. J.
Swanton, M. E.
Taylor, A. C.
Theil, G. B.
Veum, J. S.
Ward, C. E.
Weissler, J. B.
Williams, L. P.
Wright, Frank, Jr.
Young, J. J.
Zeiss, E. J.

Arcadia:
Comstock, Elizabeth
Dockendorff, B. C.
Weber, F. T.

Argyle:
Hunter, R. E.

Arpin:
Ryan, C. J.

Ashland:
Bargholtz, W. E.
Butler, Albert
Grand, C. A.
Grigsby, R. O.
Harrison, G. W.
Jauquet, J. M.
Kreher, J. E.
Larson, H. H.
Merrill, W. G.
Prentice, B. C.
Prentice, J. W.
Sandin, H. V.
Smiles, C. J.
Smiles, W. J.
Tucker, W. J.
Weeks, F. D.

Athens:
Bachhuber, G. J.

Augusta:
Moland, O G.
Thieda, E. S.

Avoca:
Reynolds, Bertha

Bailey's Harbor:
Fillbach, H. E.

Baldwin:
Olson, C. A.
Sargeant, G. M.
Torkelson, L. B.

Balsam Lake
Burdette, Stella I.

Bangor:
Ruppenthal, K. P.

Baraboo:
Edwards, A. C.
Hannan, K. D. L.
Huth, M. F.
McGonigle, B. E.
Moon, J. F.
Pearson, C. R.
Pischke, E. F.
Stoops, W. A.

Barron:
Guy, J. R.
Hammond, D. F.
Strang, C. J.
Templeton, H. M.

Bayfield:
Moody, L. W.

Bear Creek:
Morneau, L. F.

Beaver Dam:
Bayley, H. G.
Bender, R. I.
Bergen, P. M.
Boock, R. F.
Corso, Xavier
Davis, T. C.
Drescher, G. G.
Hoyer, A. A.
Hoyer, E. C.
Kores, A. B.
Qualls, C. L.
Richards, W. G.
Urbanek, R. E.
Vrabec, A. P.
Way, R. W.
Welsch, J. M.

Belgium:
Dorr, R. H.

Belleville:
Donlin, W. F.
Wells, May R.

Belmont:
Turgeson, J. F.

Beloit:
Allen, W. J.
Baldwin, R. M.
Brillman, L. P.
Carney, C. M.
Carter, K. L.
Cauldwell, E. W.
Chancey, R. L.
Clark, D. M.
Cochrane, W. L.
Cornelius, E. A.
Crockett, W. W.
Fitzgerald, W. M.
Flarity, T. H.
Fosse, Benjamin
Freeman, W. S.
Glesne, O. G.
Gunderson, R. H.
Herbert, J. W.
Johnson, F. K.
Jones, E. T.
Kasten, H. E.
Kishpaugh, H. W.
Mauermann, W. J.
Onderak, E. P.
Ottow, A. F.
Peterson, G. H.
Pollard, W. H., Jr.
Raube, H A.
Rechlitz, E. T
Sanderson, R. J.
Springberg, J. C.
Sweeney, T. C.
Thayer, R. A.
Thomson, G. H.
Twyman, A. H.
Vivian, R. S.
Wilson, R. F.

Berlin:
Koch, H. C.
Koch, J. C.
Seward, L. J.
Sievers, D. J.
Stone, G. C.
Taugher, V. J.
Wiesender, A. J.

Big Bend:
Raschbacher, J. L.

Birnamwood:
Damp, O. E.

Black River Falls:
Krohn, Robert
Marks, J. R.
Noble, J. H.
Thurow, R. M.

Blair:
Schneider, O. M.

Blanchardville:
Unterholzner, L. J.

Bloomer:
Asplund, M. W.
Clauson, C. T.
Hudek, D. F.
Murphy, P. W.

Bloomington:
Brooks, E H.
Edwards, P. K.

Boscobel:
Freymiller, E. F.
McNamee, J. R.
Randall, E. M.
Randall, M. W.

Brandon:
Lautenbach, E. T.

Brillion:
Guthrie, J. M.
Langmack, W. A.

Brodhead:
Hein, W. E.
Stuessy, M. W.

Brookfield:
Lubitz, J. M.

Brownsville:
Friedrich, L. E.
Raymond, R. G.
Ries, M. F.

Bruce:
Whalen, M. L.

Burlington:
Baker, D. J.
Erickson, L. W.
Granzeau, H. W.
Kempton, L. V.
Mastalir, L. O.
McNeel, Laird
Sroka, Wm. C.
Van Liere, J. D.

Butler:
Schoeneman, R. H.

Butternut:
Boldt, R. E.

Cadott:
Haines, B. J.
Zenner, C. E.

Cambria:
Brown, J. G.

Cambridge:
Amundson, K. K.
Nora, J. J.

Cameron:
Cronk, C. F.

Campbellsport:
Guenther, O. F.
Hoffmann, L. A.
Hogan John

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*As of December 1, 1957.

Caseo:
Kerscher, E. J.

Cashton:
Mauel, N. M.

Cassville:
David, J. J.

Cedarburg:
Blanchard, P. B.
Hurth, O. W.
Katz, H. J.
Misch, Allen

Cedar Grove:
Jensen, J. S.

Chetek:
Adams, R. W.
Kristensen, L. A.

Chilton:
Goggins, J. W.
Humke, E. W.
Humke, K. R.
Knauf, J. W.
Knauf, N. J.

Chippewa Falls:
Brown, F. J.
Graber, R. E.
Hatleberg, C. B.
Hatleberg, E. A.
Henske, W. C.
Janc, W. F.
Kemper, C. A.
Picotte, L. W.
Rahn, B. F.
Sazama, F. B.
Sazama, J. J.
Toussaint, J. B.

Clear Lake:
Campbell, L. A., Jr.

Cleveland:
Feider, A. P.

Clinton:
Thomas, W. O.

Clintonville:
Arnold, W. G.
Auld, Irving
Bate, L. C.
Boulet, W. J.
Caskey, H. S.
Larson, Owen E.
Miller, E. A.
Topp, C. A.

Cochrane:
Meili, E. A.

Colby:
Hansen, R. L.
Koch, James W.

Coleman:
Graner, L. H.

Colfax:
Felland, O. M.

Columbus:
Caldwell, H. M.
Cheli, C. F.
Poser, E. M.
Poser, J. F.
Poser, R. F.
Shearer, C. E.

Cornell:
Hendrickson, R. L.

Crandon:
Moffet, D. V.
Rathert, Burton S.

Cross Plains:
Lappley, W. F.

Cuba City:
King, C. S.
Rosmann, H. K.
Taylor, H. W., Jr.
Terry, R. E.

Cudahy:
Ackerman, D. S.
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Fine, J. M.
Frederick, J. J.
Homsey, J. J.
Kash, S. H.
Kurtin, J. J.
Lando, D. H., Jr.
Landsberg, Manfred
Malone, J. A.
Pizer, J. A.
Rosenbaum, M. K.

Cumberland:
Anderson, R. M.
Lund, R. E.
Lund, S. O.
Thompson, R. C.

Darien:
Truex, G. O.

Darlington:
McConnell, E. D.
McGreane, N. A.
Oertley, Robert E.
Olson, Lyle L.

Deerfield:
Ingwell, C. L.

De Forest:
Grinde, J. M.
Stockton, R. W.

Delafield:
Olsen, L. C. J.

Delavan:
Crowe, N. F.
Galgano, R. S.
Levin, H. M.
Martin, J. E., Jr.
O'Keefe, F. L.
Smiley, G. A.
Werbel, H. J.
Woods, Wm. C.

Denmark:
Hering, G. V.
Michna, C. T.

De Pere:
Merline, G. B.
Waldkirch, B. P.
Waldkirch, R. M.

De Soto:
Bolstad, H. A.

Dodgeville:
Buckner, H. M.
Hamilton, W. P.
Morton, H. H.
Rasmussen, N. G.
Walker, H. M.

Dousman:
Watry, T. D.

Durand:
Blose, Irvin L.
Bryant, R. J.

Eagle:
Rosenkranz, W. E.

Eagle River:
Colgan, J. J.
Jacobson, L. L.
Oldfield, R. A. A.

East Ellsworth:
Klaas, F. B.

East Troy:
Kohn, Louis

Eau Claire:
Aitken, H. M.
Anderson, F. G.
Bates, P. J.
Beebe, G. W.
Bjurstrom, R. O.
Blom, Julius
Brousseau, E. R.
Brown, R. C.
Buckley, R. A.
Cameron, W. G.
Conlon, H. J.
Copps, J. M.
Derge, H. F.
Falstad, C. H.
Fink, R. J.
Finucane, P. J.
Frank, R. C.
Fuson, H. S.
Gericke, J. T., Jr.
German, K. L.
Haag, A. F.
Halgrimson, K. W.
Hayes, E. P.
Henke, S. L.
Hilker, A. W.
Hoff, D. E.
Huston, H. C.
Ihle, C. M.
Jackson, R. D.
Kennedy, R. L.
Kilkenny, T. E.
Kinsman, F. C.
Klein, A. J.
Kundert, Elizabeth
Lorenz, A. A.
Lotz, R. M.
Lowe, J. W.
Manz, W. R.
Mason, E. L.
Mautz, W. T.
McAfee, G. D.
Midelfart, Peter
Miller, G. E.
Moberg, T. D.
Nester, H. D.
Nezworski, L. G.
Parrish, J. G., Jr.
Paulson, W. O.
Richards, R. R.
Russell, S. B.
Sorensen, H. E.
Spelbring, P. G.
Stewart, Katherine
Strand, R. C.
Thimke, H. E.
Vana, A. J.
Wahl, G. E.
Walter, K. E.
Willison, D. M.
Wishart, J. H.
Ziegler, J. E. B.

Edgar:
Schulz, H. A.

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Bowles, R. P.
Burpee, G. F.
Cohen, D. A.
Falk, V. S., Jr.
Shearer, F. E.
Sumner, W. C.
Vanstane, V. R.

Elcho:
Dailey, D. W.
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Eleva:
Martins, J. K.

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Heiden, H. H.
Martineau, J. E.

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Bill, K. C.
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Helmbrecht, M. G.
Mol, H. R.
Rawlins, J. A.
Rogers, R. J.
Sorenson, E. D.

Ellsworth
Aanes, A. R.

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Blake, W. J.
Erwin, C. P.
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Redlin, R. R.
Settimi, A. L.
Schmidt, E. A.
Wisniewski, J. H.
Zurheide, H. J.
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Elmwood
Springer, F. A.
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Elroy:
Demke, R. L.

Ettrick:
Rogne, C. O.

Evansville:
Gray, R. J.
Gray, Roger S.
Sorkin, S. S.

Fall Creek
Zboralske, F. F.

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Arnesen, P. M.
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Cullen, R. E.
Devine, H. A.
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Guth, H. K.
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Hutter, A. M.
Keenan, L. J.
Kendell, W. G.
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Steube, R. W.
Swan, J. C.
Theisen, S. A.
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Vetter, E. W.
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Wier, J. S.
Willson, D. D.
Wojta, W. C.
Yockey, J. C.

Footville:
Evenson, R. G.

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Hirschboeck, J. G.

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Hanson, O. H.
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Young, Will

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Moore, R. M.

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Gloss, A. J.

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Rohde, E. P.

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Dekker, Cornelis

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Seidl, J. A.

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Burdon, T. S.
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Cowles, R. L.
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Dettmann, J. E.
Dupont, A. J.
Durkin, T. J.
Edelblute, L. H.
Erickson, M. R.
Ford, J. L.
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Foss, R. H.
Freedman, A. L.
Fuller, M. H.
Goelz, J. R.
Gosin, F. J.
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Hagerty, W. T.
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Hammes, D. A.
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Hitch, O. M.
Icks, K. R.
Jensen, R. E.
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Kuhs, M. L.
Kulkoski, Bernard
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LeTellier, M. S.
Levitas, I. E.
McCarey, Arthur J.
McGuire, G. E.
Mickle, K. C.
Miller, L. C.
Milson, Louis
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Nellen, J. W.
Neu, V. F.
Paine, E M.
Quigley, L. D.
Robb, J. J.
Rose, R. J.
Rothe, C. A., Jr.
Saunders, O. W.
Schmidt, E. S.
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Schulz, N. H.
Shea, D. W.
Shinners, G. M.
Stauff, G. R.
Stiennon, O. A.
Sullivan, Donel
Theisen, J. K.
Troup, R. H.
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Urban, Frank
Warpinski, M. A.
Wochos, R. G.
Wunsch, C. A.
Zucker, K. L.

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Leininger, A. T.

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Olson, W. A.

Gresham:
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Puls, T. B.
Wolf, R. C.

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Kern, T. J.
Lehmann, F. W.
Monroe, M. E.
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Quandt, V. V.
Sachse, F. W.

Hartland:
Ridley, J. F.
Samuelson, Clarence

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Sandell, S. T.

Hayward:
Callaghan, D. H.
Krueger, E. R.
Sahs, M. H.
Wyant, M. E.

Hazel Green:
Murray, J. F.
Strauch, C. B.

Highland:
Erickson, M. T.

Hilbert:
Winkler, R. J.

Hillsboro:
Boston, T. E.
Leuther, P. A.
Sanford, L. L.

Hollandale:
Marshall, S. B.

Horicon:
Karsten, J. H.
Knudson, R. A.
Schutz, W. J.

Hortonville:
Bergwall, R. P.
Towne, W. H.
Van Gilder, J. H.

Hudson:
Anderson, M. G.
Bourget, G. E.
Cornwall, M. A.
Hopkins, G. J.
Newton, J. E.

Hurley:
Martinetti, D. J.

Hustisford:
Goetsch, O. F.

Independence:
Peterson, D. R.

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Knudsen, Else
Wiley, R. H.

Jackson:
Albrecht, J. E.

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Baumgartner, M. M.
Betlach, Dorothy W.
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Boutwell, W. S.
Clark, W. T.
Coyne, J. F.
Dodge, R. K.
Donkle, M. J.
Farnsworth, R. W.
Fitzgerald, G. P.
Frechette, F. M.
Freitag, S. A.
Gilbertsen, C. R.
Gutmann, G. E.
Hartlaub, E. S.
Johnson, W. L.
Klein, T. W.
Koch, V. W.
Llewellyn, M. B.
McGuire, W. H.
McSweeny, A. J.
Metcalf, G. S.
Nash, C. B.
Neeno, Katsumi
Nuzum, T. O.
Odland, P. K.
Otterholt, E. R.
Overton, R. S.
Pember, A. H.
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Purdy, M. F.
Rau, Esther L.
Reinardy, A. L.
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Schroder, John R.
Schroeder, Jack D.
Sholl, P. R.
Snodgrass, H. M.
Snodgrass, T. J.
Stevenson, C. L.
Tarrasch, Hertha
Thomas, G. L.
Tomlinson, Carol
Tordoff, J. J.
Welch, F. B.

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Busse, A. A.
Caswell, H. O.
Quandt, C. E.
Quandt, R. W.
Robinson, A. H.

Johnson Creek:
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Erickson, N. W.
Ferguson, E. C.
Heath, H. J.

Kaukauna:
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Behnke, G. A.
Boyd, G. L.
Cherkasky, Simon
Jeffrey, J. S.
Russo, J. G.

Kenosha:
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Ambro, P. J.
Andre, E. F.
Armstrong, G. F.
Ashley, R. W.
Bertolaet, E. E.
Binnie, Helen A.
Bjork, H. A.
Block, R. M.
Bode, M. J.
Boncil, B. T.
Creighton, L. H.
Creswell, C. M.
Davin, C. C.
Davis, D. W.
DeFazio, S. F.
Duncan, J. T., Jr.
Garren, J. T.
Goldstein, D. N.
Graves, J. P.
Hill, B. Spalding
Horsley, D. B.
Kappus, H. C.
Kent, L. T.
Kleinpell, W. C.
Kordecki, F. A.
Lawrence, P. J.
Lipman, W. H.
Lokvam, L. H.
Lutz, J. J.
Mayfield, A. L.
Meeter, U. L.
Milliken, L. D., Jr.
Morrow, C. A.
Mudge, W. A., Jr.
Olsman, Louis
Pearson, J. B.
Pechous, C. E.
Pechous, Lillian
Powell, R. A.
Randall, A. J.
Rattan, W. C.
Rauch, A. M.
Rauen, L. M.
Richards, J. N.
Ruehlman, D. D.
Ruffio, A. F.
Sattler, C. A.
Schlenker, L. T.
Schulte, G. C.
Schwartz, G. J.
Schwartz, H. L.
Siegel, Morris
Stewart, W. C.
Swift, W. J.
Turner, Lewis, III
Ulrich, C. F.
Weber, G. R.
Welsch, R. G.
Williams, F. C., Jr.
Wood, Fredrick, Jr.

Kewaskum:
Edwards, R. G.

Kewaunee:
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Lanier, Patricia A.
Nesemann, R. M.
Witcpalek, E. W.

Kiel:
Nauth, D. F.
Theiler, A. C.
Twohig, G. J.

Kimberly:
Curtin, D. W.
Gage, Ralph S.

Kohler:
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Rowe, D. M.

La Crosse:
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Bach, A. C.
Britt, A. G.
Buchman, D. M.
Carlsson, E. S.
Cook, A. A.
Daley, D. M.
Davies, May A.
Dietz, P. C.
Doyle, D. F.
Durst, J. B.
Egan, G. J., Jr.
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Ernst, F. W.
Flynn, R. E.
Fox, J. C.
Gallagher, E. E.
Gallagher, F. J.
Gatterdam, P. C.
Getz, Kaare
Gilbert, R. L.
Gorenstein, L. M.
Gundersen, A. H.
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Gundersen, S. B.
Gundersen, S. B., Jr.
Gundersen, T. E.
Harman, J. C.
Hickey, A. W.
Himmelsbach, W. A.
Hulick, P. V.
Jaeck, James L.
Jensen Alfhild
Jones, W. J.
Leiby, R. W., Jr.
MacEwen, A. R.
Manshcim, B. J.
McCann, John P.
McGarty, M. A.
McMahon, R. E.
McNamara, T. B.
Midelfort, C. F.
O'Meara, M. T.
Pauly, James P.
Perry, E. L.
Phillips, P. W.
Ramlow, R. W.
Rasmus, R. B.
Richter, J. R.
Satory, J. J.
Scheurich, Mary B.
Schmidt, L. R.
Schneeberger, E. J.
Sevenants, J. J.
Simones, J. J.
Sivertson, Martin
Sivertson, S. E.
Skemp, F. C.
Skemp, G. E.
Skemp, J. T.
Slungaard, Rolv
Smith, D. S.
Stang, H. M.
Swanljung, H. A.
Swarthout, Edyth C.
Uhrich, G. I.
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Wolf, F. H.

Ladysmith:

Bauer, W. B. A. J.
Bennett, R. P.
Murphy, J. E.
Pagel, H. F.

La Farge:

Gollin, F. F.

Lake Geneva:

Beattie, J. W.
Bischof, H. F.
Hindall, B. C.
Hudson, E. D.
Jeffers, D. H., Jr.

Lake Mills:

Eck, G. E.
Liebenow, R. R.
Netzow, E. J.
Peterson, M. G.
Schoenecker, E. A.

Lancaster:

Bauman, K. L.
Becher, L. E.
Carey, H. W.
Fieber, W. W.
Houghton, E. M.

Land O'Lakes:

Elckhoff, E. C.

Laona:

Castaldo, E. F.
Ovitz, E. G.

Lena:

Rose, J. F.

Little Chute:

Van Lieshout, F. X.

Lodi:

Groves, R. J.
Irwin, W. G.

Loganville:

Jewell, E. L.

Loyal:

Hable, A. P.

Luxemburg:

Majeski, H. E.

Madison:

Aageson, C. W.
Amshe, R. B.
Albright, E. C.
Allen, J. R.
Allin, R. N.
Anderson, A. D.
Anderson, Jeanne
Anderson, R. B.
Angevine, D. M.
Aronson, Abraham
Ashman, H. C.
Bamforth, Betty J.
Bartlett, W. H.
Becker, R. M.
Belknap, E. L., Jr.
Bell, P. P.
Benish, G. A.
Bennett, Maxine
Bentley, J. E.
Berger, J. V., Jr.
Berglund, George A.
Bernard, F. D.
Beyer, John A.
Bleckwenn, W. J.
Bogle, W. C.
Boldon, E. I., Jr.
Botham, R. J.
Bowers, J. Z.
Brindley, B. I.
Britton, D. M.
Brown, Henry
Brucker, E. A.
Bryan, A. W.
Buesseler, John A.
Burchman, S. L.
Burke, C. F.
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Burke, Myra E.
Burns, E. M.
Burns, R. E.
Cain, W. J.
Calvert, Charlotte
Campbell, R. E.
Canfield, Albert
Carter, H. M.
Chambers, E. L., Jr.
Chandler, Arthur, Jr.
Chase, S. L.
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Collins, R. F.
Cook, F. D.
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Cooper, G. A.
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Cranston, R. W.
Crepea, Seymour B.
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Crowley, W. P., Jr.
Crumpton, C. W.
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Davenport, Gordon
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Dean, D. L.
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Deering, H. C.
Derus, Gerald J.
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Dieter, D. G.
Dimond, W. B.
Doenlert, C. A., Jr.
Dollard, J. E.
Domine, A. Z.
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Ehrich, F. E.
Eichman, P. L.
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Ewell, G. H.
Farrell, R. X.
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Gearhart, R. S.
Geppert, T. V.
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Glover, B. H.
Golden, F. F.
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Gordon, E. S.
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Grumke, E. H.
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Hank, G. C.
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Healy, J. R.
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Hege, F. B.
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Hennen, R. J.
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Hill, N. A.
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Hoff, A. D.
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Horswill, C. W.
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Hummer, F. L.
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Lange, R. D.
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Lewis, W. C.
Liebl, E. R.
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Lipp, Evelyn D.
Littig, L. V.
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Marlow, Gordon V.
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McClung, John L.
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Schwei, G. P.

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Heyrman, D. J.
Loenhouts, K. C.
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Budny, C. L.
Buggy, W. J.
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Buszkiewicz, T. S.
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Callan, P. L.
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Costello, A. C.
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Cron, R. S.
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McCann, Edith F.
McCarty, R. T.
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McNary, J. F.
Means, J. A.
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Mellencamp, F. J.
Meloy, G. E.
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Mensing, E. H.
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Meyer, J. M.
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Miller, E. W.
Miller, H. L.
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Molsberry, J. M.
Monroe, M. W.
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Mooney, F. L.
Moore, G. E.
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Morrison, R. C.
Morter, H. V.
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Norton, R. G.
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Ohren, I. R.
O'Leary, E. B.
Olinger, J. K.
Olmstead, E. G.
Olsen, A. H.
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O'Neill, E. J.
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Osher, N. W.
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Ottenstein, H. H.
Otto, Owen
Ovitt, D. W.
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Owens, A. J.
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Panetti, H. E.
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Perssion, Leo B.
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Peters, B. J.
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Peterson, E. F.
Peterson, J. C.
Pfeffer, T. J.
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Pick, J. W.
Pierson, P. S.
Pink, J. J.
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Popp, Albert
Presti, A. A.
Price, D. J.
Prier, T. A.
Prudowsky, H. H.
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Rank, R. T.
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Raymond, A. J.
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Reifenrath, I. B.
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Rettig, E. H.
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Reuter, M. J.
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Wisniewski, P. P.
Witte, D. H.
Wolf, L. P.
Wolter, S. H.
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Wong, V. J.
Worm, G. J.
Worman, L. W.
Wright, H. H.
Wyman, J. F.
Wynn, S. K.
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Zahl, W. H.
Zaun, J. J., Jr.
Zautcke, A. B., Jr.
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Ashe, H. S.
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Sprague, J. P.

Mondovi:

Gillette, F. J.
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Sharp, D. S.
Walker, J. P.
Wright, W. E.

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Irvin, J. M.
Kindschi, L. G.
Kundert, F. W.
Miller, C. O.
Mings, D. E.
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Olson, M. J.
Schindler, J. A.
Snowden, P. W.
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Stiles, F. C.
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Witte, K. B.
Zach, R. G.
Zupanc, E. A.

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Federman, E. H.
Inman, R. F.

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Baird, H. D.
Pierpont, J. M.

Mosinee:

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Mount Calvary:

Habermann, J. H.
Miller, J. F.

Mount Horeb:

Morrison, M. T.

Mukwonago:

Kern, E. E.

Muscoda:

Ackerman, E. T.
Klockow, W. E.

Muskego:

Buhl, J. L.
Kelm, G. J.

Neenah:

Anderson, G. R.
Beatty, S. R.
Beglinger, H. F.
Bonfiglio, R. G.
Brown, R. C.
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Canavan, J. P.
Graham, A. P.
Hardie, G. H.
Henning, Laura E.
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Pansch, F. N.
Petersen, G. W.
Quade, R. H.
Regan, D. M.
Ryan, D. J.
Schwab, R. L.
Smith, F. H.
Smith, T. D.
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Manz, K. F.
Overman, M. V.
Rosekrans, M. C.
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Thompson, T. N., Jr.

Nekoosa:

Thompson, J. E.

Neopit:

Rivard, R. R.

New Franken:

Looze, J. A.

New Glarus:

Hicks, E. V.
Marty, P. H.

New Holstein:

Engel, A. C.
Larme, F. P.

New Lisbon:

Koch, C. B.
Weston, C. L.

New London:

Dernbach, G. P.
Monsted, J. W.
Pfeifer, F. J.
Schmallenberg, H. C.

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Armstrong, J. H.
Davis, R. R.
Drury, E. M.
Epley, O. H.
Healy, J. P.
Weisbrod, L. W.

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Allen, J. S.

Oconomowoc:

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Miller, G. D.
Nammacher, T. H.
Ptacek, L. J.
Rogers, A. F.
Schuele, D. T.
Stemper, Irene T.
Theobald, P. B.
Weir, E. F.
Wilkinson, D. C.
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Oconto:

Aageson, H. A.
Mohler, G. T.
Rogers, R. J.
Slaney, A. F.
Zantow, F. E.

Oconto Falls:

Culver, J. R.
Siefert, C. E.

Ogema:

Rinehart, B. M.

Omro:

Peck, D. D.
Schoenbechler, L. J.

Onalaska:

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Reay, G. R.

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Johnson, E. S.
Kellogg, L. S.

Orfordville:

McNair, E. R.

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Weller, L. J.

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Connell, F. G.
Cummings, E. F.
Danforth, H. J.
Danforth, Q. H.
Emrich, P. S.
Graber, L. D.
Graiewski, S. J.
Greenwood, Ben. S.
Guenther, V. G.
Hahn, W. V.
Haines, M. C.
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Kronzer, J. J.
Kuhn, R. V.
Leibenson, S. J.
Lockhart, J. W.
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Romberg, H. A.
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Steele, G. A.
Steen, M. H.
Strakosch, E. A.
Wagner, R. F.
Wagner, W. A.
Wheeler, W. P.
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Leasum, R. N.

Owen:

Braswell, H. M., Jr.

Palmyra:

Handeyside, R. G.

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Westcott, T. S.
Winkler, H. A.

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Leahy, J. D.
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Murphy, J. L.

Pell Lake:

Roenau, Elly A.

Peshtigo:

Barrette, Antoine

Pewaukee:

Egloff, L. W.
Kelly, J. P.

Phelps:

Schmitt, R. W.

Phillips:

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Norviel, H. B.
Rens, J. L.
Van Hecke, D. S.

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Galarnyk, I. A.

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Moffett, J. L.
Steidinger, C. L.

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Dietsch, L. C.

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Port Edwards:
Backus, O. A.

Port Washington:
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Kauth, C. P.
Savage, G. F.
Walsh, John F.

Pound:
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Shapiro, H. L.

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Edwards, W. C.
Glise, Roy C.
Hinke, D. H.
Housner, R. E.
Meyer, K. H.
Parke, George, Jr.
Pippin, B. I.
Pippin, L. M.
Sholtes, C. A.
Spear, Jack
Taft, D. J.

Rio:
Maas, W. C.

Ripon:
Bachus, A. C.
Cole, D. F.
Dittmer, O. A.
Johnson, J. M.
La Ham, J. T.
Pelton, R. S.
Schuler, W. H.
Sundeen, R. A.
Watson, E. L.

River Falls:
Cairns, R. U.
Grassl, F. O.
Gutzler, P. H.
Haskins, P. S.

Rosholt:
Benn, V. A.

St. Croix Falls:
Belshe, J. C.
Riegel, F. B.
Riegel, J. A.
Wegner, M. E.

St. Nazianz:
Foley, M. E.

Sauk City:
Bachhuber, H. A.
Kraus, B. F.
Walsh, T. W.

Seymour:
Groendahl, R. C.
Hittner, V. J.
Sieb, L. H.

Sharon:
Schrock, J. B.

Shawano:
Arvold, D. S.
Bauer, Frederick
Cantwell, A. A.
Cantwell, R. C.
Jeffries, Donald A.
Laufenburg, H. F.
Marsh, H. C.
Peterson, L. W.
Sebesta, A. J.
Toll, R. J.
Von Ruden, W. J.

Sheboygan:
Bassewitz, P. P.
Bock, A. B. C.
Bringe, J. W.
Cinelis, Ann A.
Differt, C. C.
Duckering, Florence A.
Eckardt, B. F.
Eigenberger, Friedrich
Evensen, N. A.
Gruenewald, Ludwig
Hansen, H. J.
Heinz, H. N.
Hidde, F. G.
Hildebrand, G. J.
Hildebrand, J. F.
Hoon, J. R.
Hooper, C. H.
Houfek, E. E.
Hougen, E. T.
Hulbregtse, W. G.
Juckem, G. J.
Knauf, A. J.
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Kovacic, J. F.
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Marsho, B. S.
Mason, P. B.
McRoberts, J. W.
Meier, Wm. G.
Moir, Jane M.
Moir, W. W.
Nause, F. A.
Nause, F. P.
O'Donnell, S. P.
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Pauly, R. C.
Pfeiler, A. G.
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Stannard, G. H., Jr.
Tasche, C. T.
Tasche, J. A.
Tasche, L. W.
Tompsett, A. C.
Van Driest, J. J.
Weber, C. J.
Weygandt, J. L.
Winsauer, H. J.
Wood, H. R.
Wood, R. A.
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Moen, D. V.
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La Croix, G. M.

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Conway, J. P.

Shullsburg:
Garland, D. J.
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Silver Lake:
De Witt, C. A.

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Prefontaine, K. F.

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South Milwaukee:
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Theisen, C. E.

Sparta:
Beebe, D. C.
Beebe, S. D.
Brown, J. D.
Harris, A. J.
Lukasek, E. O.
Mannis, Harry
Van Susteren, J. A.
Williams, H. H., Jr.

Spencer:
Callahan, H. T.

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Goetsch, F. H.
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Hill, E. F.

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Anderson, G. H.
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Knauf, J. A.

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Beck, J. G.
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Davies, Gwilym
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Wood, C. A.
Zietlow, F. G.

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Salan, Sam
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Reslock, C. P.
Schrank, L. W.
Schrank, R. E.
Wagner, W. A.

Wausau:
Balliet, C. M.
Bartholomew, R. D.
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Larsen, R. B.
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Miller, W. C.
Mulvaney, J. J.
Norton, W. I.
Prehn, F. C.
Rudy, W. B.
Schroth, G. J.
Shannon, R. C.
Smith, B. K.
Smith, S. M. B.
Stahmer, A. H.
Stahmer, K. H.
Stevens, G. H.
Struthers, J. L.
Trumbo, J. K.
Venables, A. J.
Wilson, O. M.
Yoran, C. M.

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Beck, A. A.
Darby, R. C.
Shemanski, L. S.
Slattery, F. G.

Wauwatosa:
Appleby, K. B.
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Boyle, R. W.
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Brandt, E. F.
Brook, J. J.
Burgardt, G. F.
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Cadden, A. V.
Coon, H. M.
Curtis, William C.
Danziger, Lewis
Denio, M. J., Jr.
Dettmann, N. F.
Deysach, L. J.
End, E. M.
Engstrom, W. W.
Feierstein, W. E.
Foregger, Richard
Glienke, C. F.
Harkness, John W.
Headlee, C. R.
Hunkel, V. H.
Jaastad, L. B.
Jennings, T. F.
Kehlnhofer, F. H.
Klopfer, W. P.
Kradwell, W. T.
Kreuter, G. C.
Liefert, K. A.
Lorton, W. L.
Lunseth, J. H.
McCormick, G. E.
McDermott, J. F.
Nordin, P. F.
O'Connell, James R.
Osgood, C. W.
Pendergast, T. J.
Pilliod, J. V.
Sanders, A. C.
Selfert, K. A.
Seymer, L. A.
Stuhler, J. D.
Whetstone, O. H.
Winters, K. J.
Wood, D. L.
Wyland, J. S.

Webster:
Maas, D. A.

West Allis:
Biljan, M. W.
Brumbaugh, E. V
Collins, E. G.
Couch, J. R.
Couch, T. T.
Cramer, R. P.
Everts, E. L.
Fais, O. G.
Franklin, S. N.
Frederick, R. H.
Fulton, J. W.
Heinan, F. C.
Hermann, W. C.
Joseph, W. A.
Malensek, M. C.
Mallin, Isadore
Miller, L. E.
Miner, D. L.
Nefches, M. S.
Ohlsen, M. P.
Smits, R. H.
Stamm, M. P.

Stern, C. S.
Stern, L. S.
Stern, R. S.
Thompson, L. L.
Toepfer, R. A.
Wilkinson, E. D.
Wilkinson, J. J.
Zenz, Carl
Zimmer, J. J.

West Bend:
Bauer, K. T.
Baumgartner, J. F
Bernhardt, E. L.
Bush, F. I.
Driessel, R. H.
Frankow, R. O.
Gibson, R. D.
Grundahl, A. T.
Heidner, A. H.
Howlett, J. R.
Kauth, P. M.
Nielsen, W. A.
Scheunemann, W. E.
Sorensen, R. F.

West De Pere:
Lenz, R. B.

West Salem:
Goedecke, R. H.
Lloyd, B. E.
Morris, D. L.
Wakefield, G. F.

Westby:
Bland, P. T.

Westfield:
Fredrick, H. Y.

Weyauwega:
Maasch, L. P.

Whitefish Bay:
Gruender, J. E. M.

Whitehall:
Hutchens, J. E.
MacCornack, R. L., Jr.
Simons, N. S.
Simonson, S. W.
Tschetter, J. S.

Whitelaw:
Gutheil, D. A.

Whitewater:
Ambrose, S. H.
Miller, R. H.

Wild Rose:
Kjentvet, R. A.
Wichmann, R. D.

Williams Bay:
Wiswell, C. Y.

Winnebago:
Bachhuber, H. M.
Colgan, H. J.
Kubiak, Mary K.
Petersik, J. T.
Schroeder, J. M.

Winneconne:
Brannon, G. H.
McDonald, D. H.

Wisconsin Dells:
Broderick, C. F.
Gissal, F. W.
Houghton, J. H

Wisconsin Rapids:
Arendt, C. J.
Arendt, N. W.
Debus, E. E.
Garrison, R. E.
Glenn, E. C.
Handy, G. H.
Hulme, A. W.
Nelson, W. L.
Pomainville, F. X.
Pomainville, H. G.
Pomainville, L. C.
Schaller, J. W.
Shields, G. G.

Withee:
Johnson, J. W.

Wittenberg:
Olson, M. H.

Wonewoc:
Baker, H. P.

Wood:
Bemis, E. L.
Bittle, K. A.
Burnett, C. H.
Carolan, J. J.
Dessel, B. H.
Hartman, A. S.
Kory, R. C.
Leitschuh, T. H
Levin, J. J.
Mateicka, W. E.
McMurry, O. R.
Meade, R. C.
Meves, T. F.
Piaskoski, R. G
Schlichting, Johanna E.
Smith, M. B.
Spencer, G. N.

Woodruff:
Hiatt, W. R.
Pfenner, O. W.

Woodville:
Heiser, P. Arthur

Wrightstown:
Vande Loo, F. B.

Wyocena:
de Neveu, A. V.

No Known Address:
Bradley, M. H.
Boyce, S. R.
Burek, A. W.
Jackson, R. C.
Krehl, W. H.
Larkin, C. B.
Lepley, Derward, Jr.
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Thackeray, R. C.

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Becker, J. F. ----------Skokie, Illinois
Bleyer, L. F. ----------Providence, Rhode Island
Bolinske, R. E. ----------St. Louis, Missouri
Bonacci, M. J. ----------St. Louis, Missouri
Bradley, H. C. ----------Oakland, California
Brooks, J. W. ----------Richmond, Virginia
Cahana, Stephen ----------Los Angeles, California
Coffin, L. E. ----------Tucson, Arizona
Costello, W. H. ----------Phoenix, Arizona
Creasy, L. E. ----------St. Petersburg, Florida
Dalton, Ruth M. ----------Philadelphia, Pennsylvania
Davee, Chalmer ----------Marion, Illinois
Davis, D. P. ----------Fatehgarh, U.P., India
Dedinsky, G. A. ----------Cupertino, California
Dekornfeld, T. J. ----------Baltimore, Maryland
Fabric, B. L. ----------Miami Beach, Florida
Flynn, R. A. ----------St. Paul, Minnesota
Ford, A. McD. ----------Palmdale, California
Foster, J. J. ----------Washington, D. C.
Foster, T. D. ----------Takoma Park, Maryland
Froede, H. E. ----------Washington, D. C.
Grant, L. C., Jr. ----------North Nigeria, West Africa
Helm, H. M. ----------Rockton, Illinois
Henke, F. W. ----------Edina, Minnesota
Holbrook, A. T. ----------Dunedin, Florida
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Hugo, G. J. ----------Alhambra, California
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Johnson, Rhoda E. ----------Evanston, Illinois
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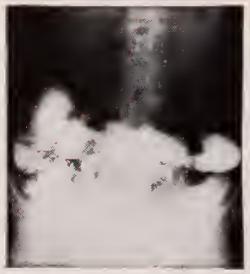
Washburn, R. G. ----------Milwaukee
Wheeler, W. P. ----------Oshkosh

when anxiety and tension "erupts" in the G. I. tract...

IN ILEITIS



PATHIBAMATE*

Meprobamate with PATHILON® Lederle

Combines Meprobamate (*400 mg.*) the most widely prescribed tranquilizer . . . helps control the "emotional overlay" of ileitis — without fear of barbiturate loginess, hangover or habituation . . . *with* PATHILON (*25 mg.*) the anticholinergic noted for its extremely low toxicity and high effectiveness in the treatment of many G.I. disorders.

Dosage: 1 tablet t.i.d. at mealtime. 2 tablets at bedtime. *Supplied:* Bottles of 100, 1,000.

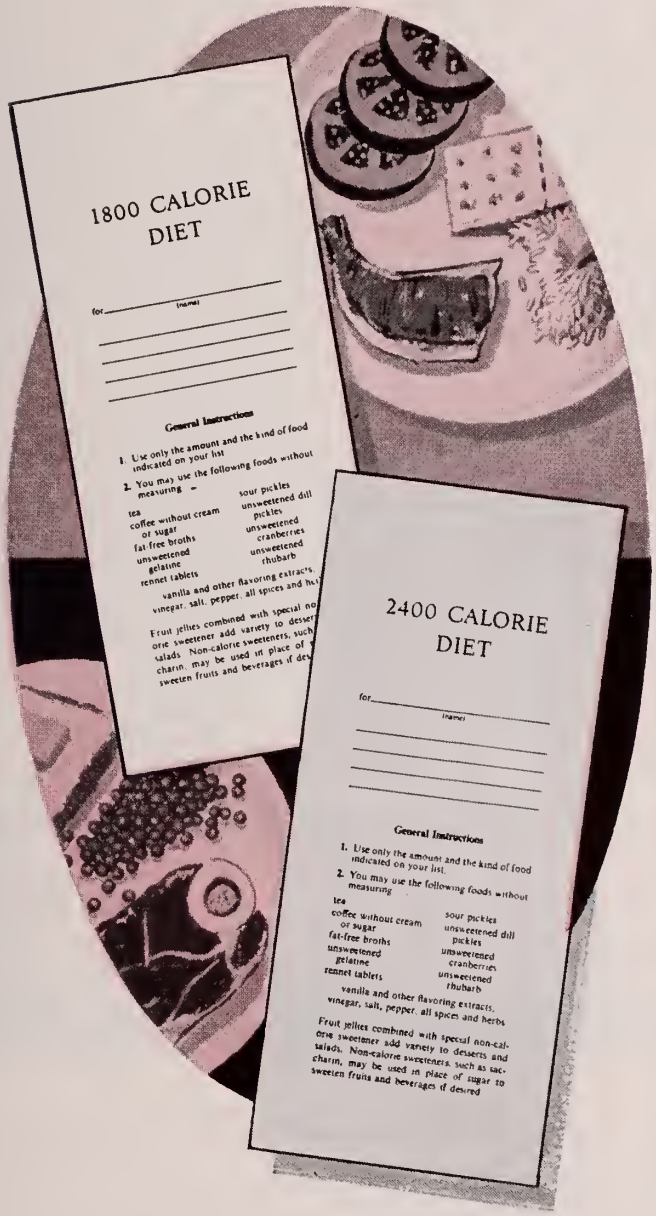
*Trademark ® Registered Trademark for Tridihexethyl Iodide Lederle

Lederle

LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

THESE DIETS CAN HELP YOU MANAGE YOUR PATIENTS WITH

high blood cholesterol levels



Upon your request, The Armour Laboratories will be pleased to send you a complimentary supply of 1800 and 2400 calorie diets . . . low in carbohydrate and high in unsaturated fats . . . intended for use in conjunction with ARCOFAC, the Armour preparation designed to lower elevated blood cholesterol.

Arcofac need be taken only once a day . . . in relatively small amounts . . . and allows the patient to eat a balanced, nutritious and palatable diet.

Each tablespoonful of ARCOFAC emulsion contains:

Linoleic acid* . . . . 6.8 Gm.
Vitamin B_6 . . . . . 0.6 mg.
Mixed tocopherols (Vitamin E) . . . . 11.5 mg.

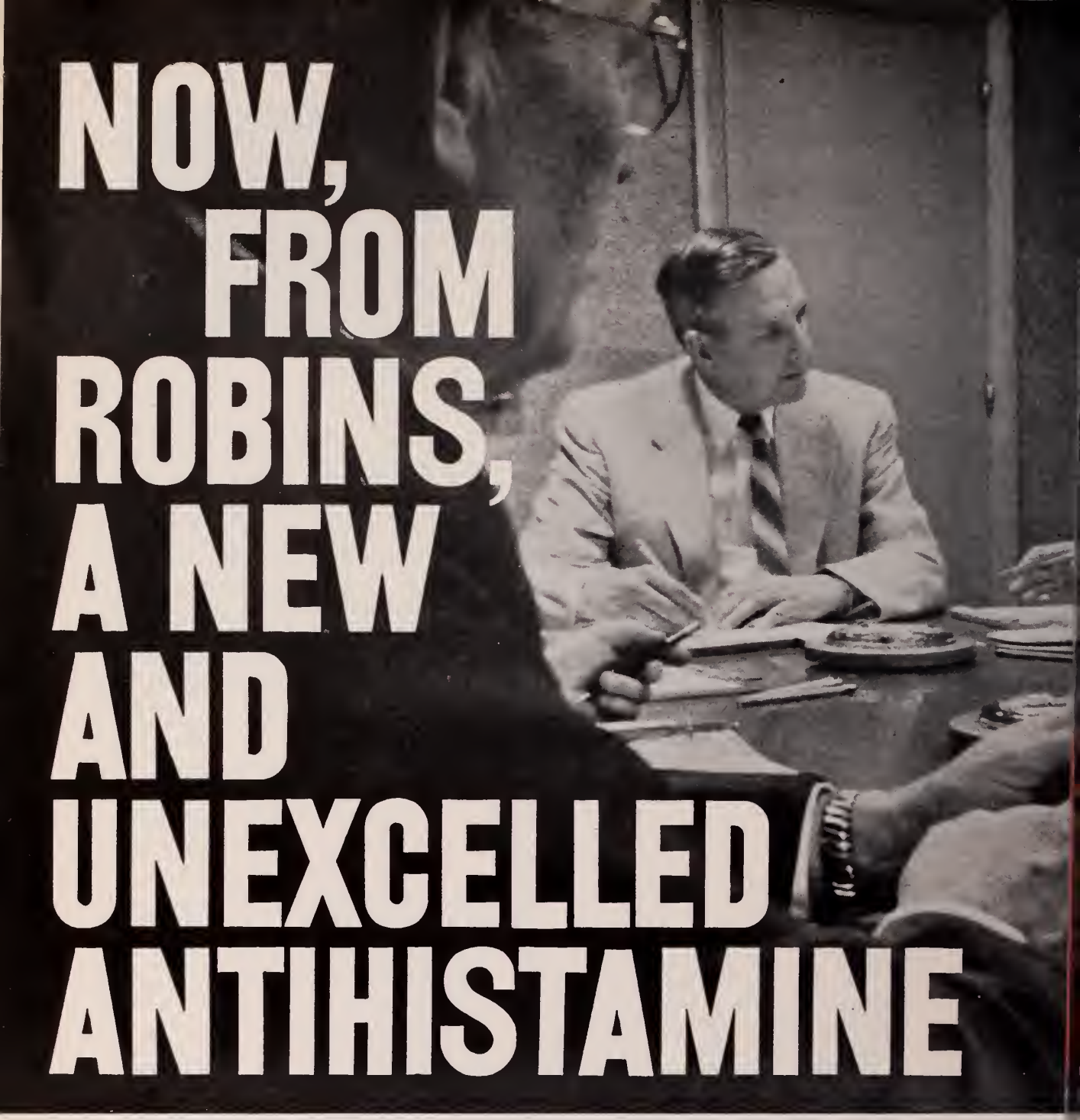
*derived from safflower oil which contains the highest concentration of unsaturated fatty acids of any commercially available vegetable oil.

Arcofac is available in bottles of 12 fluid ounces.

THE ARMOUR LABORATORIES

A DIVISION OF ARMOUR AND COMPANY • KANKAKEE, ILLINOIS

NOW, FROM ROBINS, A NEW AND UNEXCELLED ANTIHISTAMINE



why Dimetane is the best reason yet for you to re-examine the antihistamine you're now using

» *Milligram for milligram, DIMETANE potency is unexcelled.* DIMETANE has a therapeutic index unrivaled by any other antihistamine—a relative safety unexceeded by any other antihistamine. DIMETANE, even in very low dosage, has been effective when other antihistamines have failed. Drowsiness, other side effects have been at the very minimum.

Diagnosis	No. of Patients	Response				Side Effects
		Excellent	Good	Fair	Negative	
Allergic rhinitis and vasomotor rhinitis	30	14	9	5	2	Slight Drowsiness (3)
Urticaria and angioneurotic edema	3	1	1	1		Dizzy (1)
Allergic dermatitis	2		1	1		Slight Drowsiness (2)
Bronchial asthma	1		1			
Pruritus	1		1			
Total	37	15	13	7	2	Drowsiness (5) Dizzy (1) 16.2%

From the preliminary **Dimetane Extentabs** studies of three investigators. Further clinical investigations will be reported as completed

» unexcelled antihistaminic action

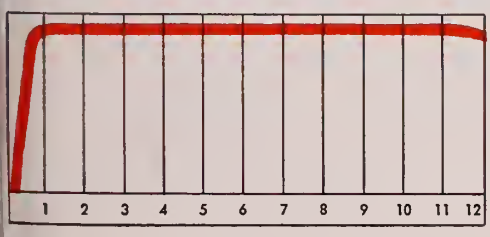
Dimetane®

it's easy to remember **Di′me tane**

ETANE® EXTENTABS® TABLETS ELIXIR

DIMETANE IS PARABROMDYLAMINE MALEATE — EXTENTABS 12 MG., TABLETS 4 MG., ELIXIR 2 MG. PER 5 CC.

a blanket of allergic protection, covering 10-12 hours—with just one Dimetane Extentab » *DIMETANE Extentabs protect patient for 10-12 hours on one tablet.*



Periods of stress can be easily handled with supplementary DIMETANE Tablets or Elixir to obtain maximum coverage.

Dosage:

Adults—One or two 4-mg. tabs. or two to four teaspoonfuls Elixir, three or four times daily. One Extentab q.8-12 h. or twice daily.
Children over 6—One tab. or two teaspoonfuls Elixir t.i.d. or q.i.d., or one Extentab q.12h.
Children 3-6—½ tab. or one teaspoonful Elixir t.i.d.

A. H. ROBINS CO., INC.

Robins

Richmond, Virginia | Ethical Pharmaceuticals of Merit Since 1878

new

"flavor-timed"

dual-action

coronary vasodilator

Dilcoron

TRADEMARK

ORAL

for **Sustained** *coronary vasodilation and protection against anginal attack*

SUBLINGUAL

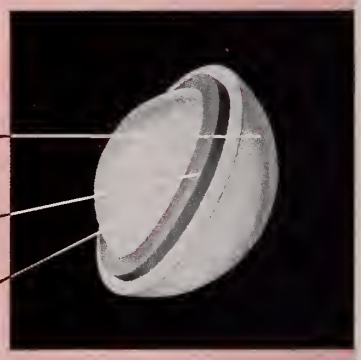
for **Immediate** *relief from anginal pain*

DILCORON contains two highly efficient vasodilators in a unique core-and-jacket tablet.

Glyceryl trinitrate (nitroglycerin)—0.4 mg. (1/150 grain) is in the outer jacket—held under the tongue until the citrus flavor disappears; provides rapid relief in acute or anticipated attack.

The middle layer of the tablet is the citrus "flavor-timer."

Pentaerythritol tetranitrate—15 mg. (1/4 grain) is in the inner core—swallowed for slow enteric absorption and lasting protection.

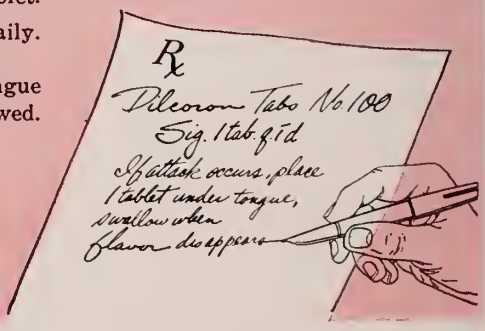


Bottles of 100.

For continuing prophylaxis patients may swallow the entire Dilcoron tablet.

Average prophylactic dose: 1 tablet four times daily.

Therapeutic dose: 1 tablet held under the tongue until citrus flavor disappears, then swallowed.



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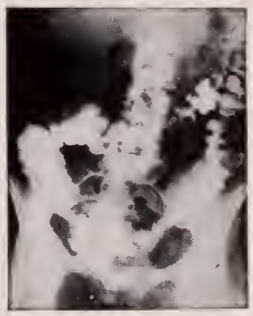
Past Presidents of the State Medical Society

Mason C. Darling, Fond du Lac 1841–1847
J. B. Dousman, Milwaukee 1848, 1849
A. L. Castleman, Delafield 1850, 1851
Harmon Van Dusen, Mineral Point 1852, 1853, 1854
A. L. Castleman, Delafield 1855
John Mitchell, Janesville 1856
D. Cooper Ayres, Green Bay 1857
Clark G. Pease, Janesville 1858, 1859
E. S. Carr, Madison 1860, 1861
Solomon Blood, Rochester 1862
(No meetings held from 1863 through 1866; apparently no new officers).
Harmon Van Dusen, Mineral Point 1867, 1868, 1869
Solon Marks, Milwaukee 1870
H. P. Strong, Beloit 1871
John Favil, Madison 1872
Harmon Van Dusen, Mineral Point 1873
M. Waterhouse, Portage 1874
J. T. Reeve, Appleton 1875
J. B. Whiting, Janesville 1876
J. K. Bartlett, Milwaukee 1877
Darius Mason, Prairie du Chien 1878
Nicholas Senn, Milwaukee 1879
J. G. Meachem, Sr., Racine 1880
Ira Manley, Jr., Markesan 1881
William Meacher, Portage 1882
T. P. Russell, Oshkosh 1883
N. M. Dodson, Berlin 1884
E. W. Bartlett, Milwaukee 1885
G. M. Steele, Oshkosh 1886
S. C. Johnson, Hudson 1887
L. G. Armstrong, Boscobel 1888
J. R. Barnett, Neenah 1889
E. M. Rogers, Hartford 1890
G. D. Ladd, Milwaukee 1891
G. F. Witter, Grand Rapids, Mich. 1892
B. T. Phillips, Menominee, Mich. 1893
B. C. Brett, Green Bay 1894
Almon Clarke, Sheboygan 1895
F. W. Epley, New Richmond 1896
B. O. Reynolds, Lake Geneva 1897
William Mackie, Milwaukee 1898
Herman Reineking, Milwaukee 1899
W. T. Sarles, Sparta 1900
J. F. Pritchard, Manitowoc 1901
W. H. Neilson, Milwaukee 1902
J. V. R. Lyman, Eau Claire 1903

when anxiety and tension "erupts" in the G. I. tract...

in spastic and irritable colon



PATHIBAMATE*

Meprobamate with PATHILON® Lederle

Combines Meprobamate (*400 mg.*) the most widely prescribed tranquilizer... helps control the "emotional overlay" of spastic and irritable colon—without fear of barbiturate loginess, hangover or habituation ... *with* PATHILON (*25 mg.*) the anticholinergic noted for its extremely low toxicity and high effectiveness in the treatment of many G.I. disorders.

Dosage: 1 tablet t.i.d. at mealtime. 2 tablets at bedtime. *Supplied:* Bottles of 100, 1,000.

*Trademark ® Registered Trademark for Tridihexethyl Iodide Lederle

Lederle

LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

F. E. Walbridge, Milwaukee 1904
C. W. Oviatt, Oshkosh 1905
J. R. Currens, Two Rivers 1906
L. H. Pelton, Waupaca 1907
W. E. Ground, Superior 1908
Gilbert E. Seaman, Madison 1909
Edward Evans, La Crosse 1910
Byron M. Caples, Waukesha 1911
John M. Dodd, Ashland 1912
Arthur J. Patek, Milwaukee 1913
Charles S. Sheldon, Madison 1914
T. J. Redelings, San Diego, Cal. 1915
L. J. Jermain, Milwaukee 1916
Hoyt E. Dearholt, Milwaukee 1917
Gustave Windesheim, Kenosha 1918
D. J. Hayes, Milwaukee 1919
C. R. Bardeen, Madison 1920
H. W. Abraham, Appleton* 1921
M. A. McGarty, La Crosse 1921
S. Hall, Ripon 1922
F. G. Connell, Oshkosh 1923
Rock Sleyster, Wauwatosa 1924
Wilson Cunningham, Platteville 1925
Joseph F. Smith, Wausau 1926
Arthur W. Rogers, Oconomowoc 1927
John J. McGovern, Milwaukee 1928
Karl W. Doege, Marshfield 1929
F. J. Gaenslen, Milwaukee 1930
A. J. McDowell, Soldiers Grove** 1931
C. A. Harper, Madison 1931
Otho Fiedler, Sheboygan 1932
Reginald H. Jackson, Madison 1933
Stanley J. Seeger, Texarkana, Texas 1934
T. J. O'Leary, Superior 1935
R. M. Carter, Green Bay 1936
Stephen E. Gavin, Fond du Lac 1937
James C. Sargent, Milwaukee 1938
A. E. Rector, Appleton 1939
R. G. Arveson, Frederic 1940
R. P. Sproule, Milwaukee 1941
Gunnar Gundersen, La Crosse 1942
F. E. Butler, Menomonie 1943
R. M. Kurten, Racine 1944
Charles Fidler, Milwaukee 1945
P. R. Minahan, Green Bay 1946
C. A. Dawson, River Falls 1947
W. D. Stovall, Madison 1948
K. H. Doege, Marshfield 1949
J. W. Truitt, Milwaukee 1950
H. H. Christofferson, Colby 1951
A. H. Heidner, West Bend 1952
J. C. Griffith, Milwaukee 1953
H. Kent Tenney, Madison 1954
Arthur J. McCarey, Green Bay*** 1955
Ervin L. Bernhart, Milwaukee 1955
L. O. Simenstad, Osceola 1956

* Died during term of office as president-elect.
** Resigned, because of health, prior to taking office.
*** Through April, 1955. The date of the Society's Annual Meeting, at which the president is elected, was changed from October to May during this year.

Recipients of the Council Award

Established in 1929, the Council Award represents the highest award in the power of the State Medical Society to bestow upon one of its members or, at times, on one closely connected with the work of the profession in the state. It is granted only upon occasion. It is granted only by unanimous vote of the Council. It is granted only to such as have served with outstanding distinction the science of medicine, their fellow physicians, and the public.

Of those who have been its recipients, it may truly be said that they have personified the highest traditions of medicine in their devotion to the public good.

Dr. John M. Dodd† 1930
Dr. Cornelius A. Harper† 1930
Dr. John J. McGovern† 1931
Dr. Louis M. Jermain† 1931
Dr. Edward Evans† 1931
Dr. Mina B. Glasier† 1932
Dr. Arthur W. Rogers† 1934
Dr. Rock Sleyster† 1934
Dr. Olin West† 1934
Edward A. Birge, Ph. D.**† 1935
Dr. Arthur J. Patek† 1935
Dr. Joseph F. Smith† 1937
Dr. Eben J. Carey† 1938
Dr. William S. Middleton 1938
Dr. Fred G. Johnson† 1939
Dr. William D. Stovall 1940
Dr. Ludvig Hektoen***† 1941
Dr. Stephen E. Gavin 1944
Dr. F. Gregory Connell 1947
Dr. E. R. Schmidt 1949
Dr. Armand J. Quick 1950
Dr. F. A. Stratton† 1951
Dr. Gunnar Gundersen 1953
W. J. Meek, Ph.D. 1953
Dr. R. G. Arveson 1957

** Then president of the University of Wisconsin and professor of zoology.
*** Centennial Award.
† Deceased.

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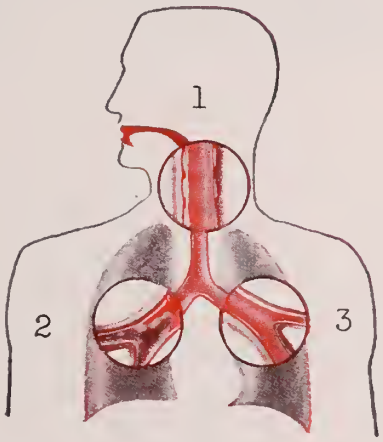
breaks up cough*



*Drawing shows how 3-pronged attack of Pyribenzamine Expectorant with Ephedrine breaks up cough by: (1) reducing histamine-induced congestion and irritation throughout the respiratory tract; (2) liquefying thick and tenacious mucus; (3) relaxing bronchioles. Pyribenzamine Expectorant with Codeine and Ephedrine also available (exempt narcotic). Pyribenzamine® citrate (tripelennamine citrate CIBA). C I B A

new for angina

PETN + ATARAX®

(PENTAERYTHRITOL TETRANITRATE) (HYDROXYZINE)

CARTRAX*

links
freedom from
anginal attacks

with a shelter of
tranquility

In pain. Anxious. Fearful. On the road to cardiac invalidism. These are the pathways of angina patients. For fear and pain are inexorably linked in the angina syndrome.

For angina patients—perhaps the next one who enters your office—won't you consider new CARTRAX? This doubly effective therapy combines PETN (pentaerythritol tetranitrate) for lasting vasodilation and ATARAX for peace of mind. Thus CARTRAX relieves not only the anginal pain but reduces the concomitant anxiety.

Dosage and supplied: begin with 1 to 2 yellow CARTRAX "10" tablets (10 mg. PETN plus 10 mg. ATARAX) 3 to 4 times daily. When indicated, this may be increased for more optimal effect by switching to pink CARTRAX "20" tablets (20 mg. PETN plus 10 mg. ATARAX.) For convenience, write "CARTRAX 10" or "CARTRAX 20." In bottles of 100. CARTRAX should be taken 30 to 60 minutes *before* meals, on a continuous dosage schedule. Use PETN preparations with caution in glaucoma.

"Cardiac patients who show significant manifestations of anxiety should receive ataractic treatment as part of the therapeutic approach to the cardiac problem."[1]

1. Waldman, S., and Pelner, L.: Am. Pract. & Digest Treat. *8*:1075 (July) 1957.

*TRADEMARK

New York 17, New York
Division, Chas. Pfizer & Co., Inc.

STOP respiratory congestion orally

relief in minutes..lasts for hours

In the common cold, nasal allergies, sinusitis, and postnasal drip, one timed-release Triaminic tablet brings welcome relief of symptoms *in minutes*. Running noses stop, clogged noses open—and *stay* open for 6 to 8 hours. The patient can breathe again.

With *topical* decongestants, "unfortunately, the period of decongestion is often followed by a phase of secondary reaction during which the congestion may be equal to, if not greater than, the original condition. . . ."* The patient then must reapply the medication and the vicious cycle is repeated, resulting in local overtreatment, pathological changes in nasal mucosa, and frequently "nose drop addiction."

Triaminic does not cause secondary congestion, eliminates local overtreatment and consequent nasal pathology.

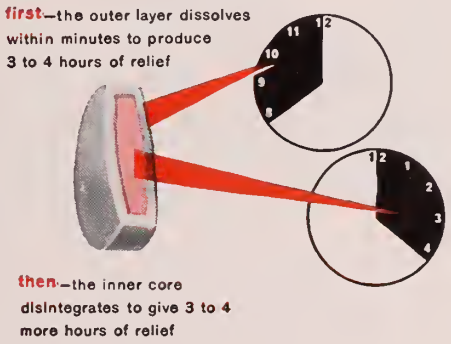
*Morrison, L. F.: Arch. Otolaryng. 59:48-53 (Jan.) 1954.

Each double-dose "timed-release" TRIAMINIC *Tablet contains:*

Phenylpropanolamine hydrochloride	50 mg.
Pyrilamine maleate	25 mg.
Pheniramine maleate	25 mg.

Dosage: 1 tablet in the morning, afternoon, and in the evening if needed.

Each double-dose "timed-release" tablet keeps nasal passages clear for 6 to 8 hours—provides "around-the-clock" freedom from congestion on just three tablets a day



Also available: Triaminic Syrup, for children and those adults who prefer a liquid medication.

Triaminic® "timed-release" tablets

STOP *running noses . . . and open stuffed noses orally*

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska • Peterborough, Canada

THESE GUIDES MAY HELP YOU

The following guides and manuals are available without cost upon request to the State Medical Society office, Box 1109, Madison 1, Wisconsin:

1. **Interprofessional Code**—An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.
2. **Civil Defense Manual for Mobile Medical Team Personnel**—An explanation of the Wisconsin program for civil defense and the role of mobile medical teams in that program.
3. **Code of Necropsy Procedure**—A guide to physicians, hospitals, and funeral directors in the performance of necropsies.
4. **Guide for the Development of a Local or Regional Rheumatic Fever Program**—Recommendations for a model plan of rheumatic fever program emphasizing the convalescent home, diagnostic and follow-up clinics, and a home-service program.
5. **Hearing Conservation Programs for Wisconsin Industries** — Some recommended standards and principles for providing a hearing conservation program in industry.
6. **Industrial Health, A Guide for Medical and Nursing Personnel**—General principles and suggested procedures for an industrial health program, especially in relation to standing orders for nurses.
7. **Medical Care of Migrant Agricultural Workers**—A guide to physicians and operators of licensed industrial camps in Wisconsin on the formulation of a local plan for the care of migrant workers.
8. **Minimum Standards of Medical Care for County Hospitals** — A guide to physicians and county asylum superintendents concerning medical care for patients in county hospitals.
9. **Participation by Physicians in Radio and Television Programs** — A guide to physicians and county medical societies for their presentation of or participation in radio and television programs.
10. **Planning Your Career as a Medical Associate**—A brochure to acquaint young people with the careers open to them in fields related to medicine.
11. **School Health Examinations**—A guide for physicians and school authorities in establishing a program of school health examinations.
12. **School Vision Screening Program**—An outline to facilitate the development of a program to detect significant visual defects among school children.

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the new Univis I.S./22 multifocal

—the lens with the completely-identifiable segment

✳ Distinctive shape of segment gives positive identification ✳ Distinctive style protects you and your patients from imitation ✳ UNIVIS quality design and manufacture assures maximum patient satisfaction

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- Unsurpassed front surface quality
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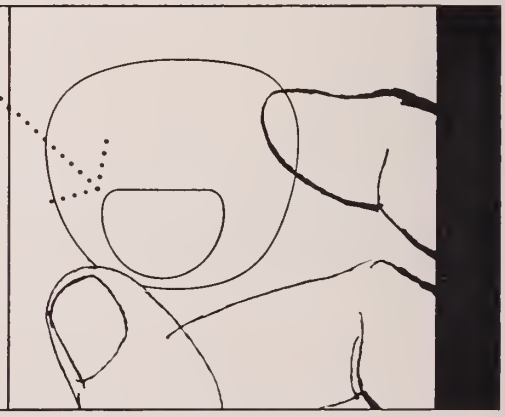
- Accurate segment power

Of course . . .
famous UNIVIS quality throughout!



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Laboratories Serving Wisconsin: **Beloit, Eau Claire, La Crosse, Stevens Point, Superior and Wausau, Wis.; and Duluth, Minn.**

minor chemical changes can mean major therapeutic improvements

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The most efficient of all anti-inflammatory steroids

- Lower dosage (⅓ lower dosage than prednisolone)
- Better tolerated (less sodium retention, less gastric irritation)

Supplied: Tablets of 4 mg., in bottles of 30, 100 and 500.

*TRADEMARK FOR METHYLPREDNISOLONE, UPJOHN

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"Since we put him on NEOHYDRIN he's been able to stay on the job without interruption."

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1958

The Wisconsin Medical Journal

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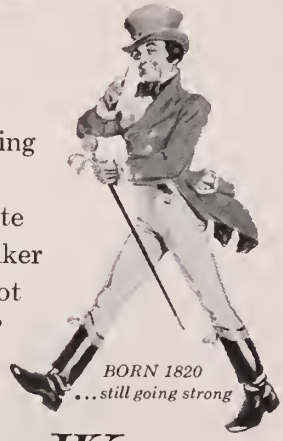

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CANCER FILMS AVAILABLE

The 20 sound-color cancer films listed below, with accompanying summary pamphlets, are available from the Wisconsin Division, American Cancer Society, 704 East Gorham Street, Madison.

They were originally telecast from New York City and films were made from the closed-circuit colored presentations, the project being sponsored jointly by the American Cancer Society and the Columbia Broadcasting System.

Designed for professional information and presentation of current knowledge about diagnosis and treatment, the films present a consensus of opinion approved and substantiated by the majority of clinical and research workers. The films were initially screened by a national committee of physicians, who supervised revisions and condensations. Some of the medical men featured in the series: Drs. Alfred Gellhorn, Cornelius Rhoads, Howard Taylor, George Pack, Hayes Martin, and George Papanicolaou.

- Cancer Detection* (38 min.)
- Lymphomas and Leukemias* (55 min.)
- Cancer of the Urinary Bladder (48 min.)
- Cancer of the Oral Cavity (35 min.)
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- Moles and Melanomas* (49 min.)
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- Cancer of the Cervix (32 min.)
- Cancer of the Colon and Rectum (39 min.)
- Tumors of Bones* (49 min.)
- Head and Neck Cancer* (45 min.)
- The Diagnosis of Breast Cancer (45 min.)
- Cancer of the Central Nervous System (30 min.)
- The Management of Advanced Cancer (46 min.)
- Cancer of the Lung* (45 min.)
- Hormonal and Chemical Treatment of Cancer (52 min.)

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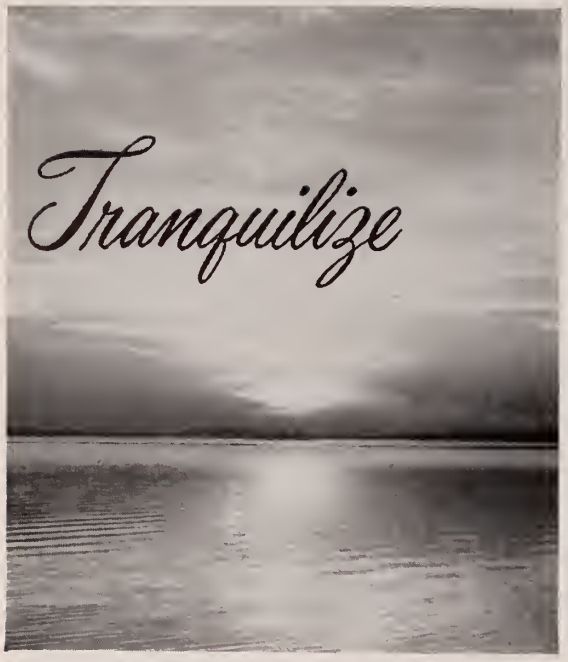

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(Continued on page 79)

(Continued from page 78)

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Ashland–Bayfield–Iron	J. E. Kreher 522 W. Second Ashland	J. M. Jauquet 220 Seventh, W. Ashland	
Barron–Washburn–Sawyer–Burnett	D. V. Moen Shell Lake	H. M. Templeton Barron	Second Tuesday 7:30 p.m.
Brown	George Nadeau 128 E. Walnut Green Bay	Frank Urban 305 E. Walnut Green Bay	Second Thursday*
Door–Kewaunee	J. G. Beck Sturgeon Bay	J. F. March 413 4th Algoma	
Calumet	J. A. Knauf Stockbridge	K. R. Humke Chilton	
Chippewa	F. J. Brown 116½ N. Bridge Chippewa Falls	R. L. Hendrickson 12 Third Cornell	Second Tuesday
Clark	T. N. Thompson, Jr. Neillsville	H. M. Braswell, Jr. Owen	
Columbia–Marquette–Adams	H. A. Winkler 115 W. Chestnut Pardeeville	T. S. Westcott Pardeeville	Every Third Month 7:00 p.m.
Crawford		H. L. Shapiro Prairie du Chien	Third Wednesday
Dane	E. J. Nordby 1 S. Pinckney Madison	A. P. Schoenenberger 224 W. Washington Madison	Second Tuesday Sept. through June
Dodge	R. F. Boock 119½ Front Beaver Dam	G. G. Drescher 106½ Front Beaver Dam	Last Thursday*
Douglas	Charles Giesen 1514 Ogden Superior	E. G. Stack 1225 Tower Superior	First Wednesday** Hotel Superior
Eau Claire–Dunn–Pepin	D. M. Willison 314 E. Grand Eau Claire	K. E. Walter 131 S. Barstow Eau Claire	Last Monday
Fond du Lac	John C. McCullough 20 Forest Fond du Lac	R. W. Schroeder 330 Ledgeview Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley Wabeno	D. V. Moffet Crandon	
Grant	K. L. Bauman Lancaster	H. W. Carey Lancaster	Last Thursday, March, June, Sept. and Nov.
Green	M. W. Stuessy Brodhead	R. G. Zach Monroe Clinic Monroe	
Green Lake–Waushara	G. G. Mueller Princeton	J. C. Koch Berlin	Last Thursday, every other month starting in Jan.
Iowa	C. L. White Mineral Point	E. J. Hohler Mineral Point	First Thursday following first Monday
Jefferson	E. E. Burzynski 113 N. Third Watertown	E. P. Schuh 706 Madison Watertown	Third Thursday*
Juneau	J. H. Vedner Mauston	J. S. Hess Mauston	Second Tuesday Hess Clinic in Mauston

* Except June, July, and August.

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COUNTY	PRESIDENT	SECRETARY	MEETING DATE
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Lafayette	R. E. Oertley Darlington	D. J. Garland Shullsburg	Last Tuesday
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Manitowoc	J. W. Steckbauer Suite 304, Savings Bank Building Manitowoc	R. J. Banker 709 Washington Manitowoc	Last Thursday
Marathon	Helen C. Davis 1302 Grand Wausau	R. B. Larsen 510½ Third Wausau	
Marinette–Florence	C. H. Boren Marinette	K. G. Pinegar 516 Houston Marinette	Third Wednesday St. Joseph's Hospital
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Polk	Stella I. Burdette Balsam Lake	L. J. Weller Osceola	Third Thursday 7:00 p.m.
Portage	H. A. Anderson River Pines Sanatorium Stevens Point	W. A. Gramowski 319½ Main Stevens Point	
Price–Taylor	E. B. Elvis Medford	J. J. Leahy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
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Walworth	C. Y. Wiswell Williams Bay	H. R. Mol Elkhorn	Second Thursday*
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Waukesha	James V. Bolger, Jr. 102 E. Main Waukesha	Philip Wilkinson 618 W. La Belle Oconomowoc	First Wednesday
Waupaca	Owen Larson Clintonville	H. S. Caskey Clintonville	
Winnebago	P. S. Emrich 456 Mt. Vernon Oshkosh	G. B. Hildebrand 216½ Main Menasha	First Thursday
Wood	E. C. Glenn 132 E. Grand Wisconsin Rapids	N. J. Helland 650 S. Central Marshfield	Four times a year

* Except June, July, and August.

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MEDICOLEGAL FORMS
With Legal Analysis

The forms and text which follow are taken, with permission, from a brochure entitled Medicolegal Forms published by the Law Department of the American Medical Association, copyright, 1957. The original brochure has been followed without change except that where Wisconsin law differs from the position indicated in the brochure, the text, and in some cases the forms, have been modified accordingly. It should also be emphasized that what follows is limited to certain legal implications of medical practice. It is not concerned with the ethical aspects of those same acts.

The Editor

Many physicians and hospitals throughout the United States do not follow the practice of requiring the signing of appropriate medicolegal forms in situations where experience has shown that the signing of such forms might have prevented a law suit. In other instances, inadequate medicolegal forms are in daily use. For example, "blanket" consent forms which purport to give the physician unlimited authority and discretion without specifying the particular operation contemplated are used extensively. The use of such forms has given rise to professional liability claims charging the performance of an operation different than the one for which consent was obtained. The courts have construed blanket consent forms to permit only the procedures which were orally agreed upon. In the absence of a consent form that describes within reasonable latitude the nature of the operation or treatment to be performed, a jury can very easily choose to believe the "forgetful" patient whose recollection regarding the treatment he authorized has been dimmed by time or circumstances.

In 1936, an article entitled "Authorization of Physical Examinations" by Dr. William C. Woodward was published in THE JOURNAL (106 J.A.M.A. 33). The present work has a twofold objective: (1) to expand and bring up-to-date the subject matter covered by Dr. Woodward, and (2) to provide miscellaneous medicolegal forms of authorization and consent which physicians and their attorneys may adapt to their own needs.

In preparing these forms for publication, no effort has been made to provide complete uniformity, even with respect to details or format. Generally, the variations which exist do not have any particular legal significance. For example, some of the forms call for the addresses of the signer and the witnesses. Dependent upon local preference and circumstance, it may be preferable to include such addresses in a consent form. On the other hand, where the physician or the hospital already has this information in its records, it would be unessential. It may not be necessary to include the address of an employee witness since this information is usually available elsewhere. When the patient is accompanied by a friend or relative, it is a good policy to have this person sign as a witness and furnish his address, which may be stated either in the form or elsewhere in the patient's record. In these instances it is also desirable that an employee of the physician or hospital sign as a second witness.

If the patient is a minor, and someone else signs the form on his behalf, the relationship, if not apparent, should be stated in the consent form.

In our opinion, revised and up-to-date medicolegal forms should be available to physicians and should be executed by the patient in the physician's office, whenever circumstances permit, even though the hospital may also require the patient to sign similar consent forms. Local legal counsel should be consulted to make such changes in the suggested forms as are necessary to satisfy the laws of the jurisdiction.

Although numerous court decisions and statutes have been cited, neither the citations nor the text are exhaustive and therefore should not be relied upon by the reader to ascertain the exact status of the law in his jurisdiction or to solve a specific legal problem. The text and forms have been prepared to help physicians and hospitals but at best, they are a poor substitute for competent local legal advice.

Chapter I

CONSENT TO OPERATIONS AND OTHER PROCEDURES

This chapter is written in terms of consent to surgical operations. However, the principles of law set forth herein are equally applicable to the other examinations, procedures or treatments in which the physician engages.

Assault and Battery

Authority is necessary before a physician may legally examine or treat a patient. A physician who operates upon a patient without having authority to do so, commits an assault and battery for which he may be prosecuted criminally or held civilly liable in damages.[1] If the patient upon whom the unauthorized operation was performed is unable to prove that any actual damage was caused by the operation, he will usually be able to recover only nominal damages.[2] However, the fact that the medical profession has not yet discovered the purpose served by the organ removed will not necessarily limit the patient's recovery to nominal damages; pain and suffering is an element of damages in assault and battery and some pain may be presumed to occur in the course of any operation or in the course of recovering therefrom.[3]

It is no defense that the unauthorized operation was performed with due skill and care inasmuch as negligence is not an element of this cause of action.[4] Authority for the performance of an operation may arise out of a legal duty or out of the consent of the patient or some one authorized to act in his behalf. In an emergency, authority is implied on the basis that it would probably have been granted.

Authority Provided by Law

Some states provide, by statute, for the eugenic sterilization of feeble-minded persons and habitual criminals.[5] If the law under which the operation has been authorized is a valid, constitutional law,[6] and if the procedure leading up to the order for sterilization has been in conformity with that law,[7] and if the operation is performed in accordance with the law and without negligence, the physician authorized to perform the operation incurs no personal liability in performing it even over the objection of the person upon whom he operates.

Similarly, statutory authority protects physicians in charge of state mental institutions, prison physicians,[8] and health officers charged with the enforcement of vaccination and quarantine laws. The conduct of all such officers is subject to review by the courts. If they act beyond the scope of their authority, or if they act in an unlawful manner, they are liable for the payment of damages and may be subject to criminal prosecution.

Authority Provided by Consent

Usually authority to operate arises from the valid consent of the patient or some one legally authorized to act in his behalf. It should be noted that even a valid consent is no defense in an action for professional negligence.[9] The consent given may be either express or implied and, if express, it may be either written or oral.[10] The consent given must be an informed consent with an unstanding of what is to be done and of the risks involved.[11] The procedure involved and its attendant risks should be explained to the patient in understandable non-technical terms. The consent given may be invalid (a) because the act consented to is unlawful,[12] or contrary to public policy,[13] or (b) because the consent was given by one who had no legal right to give it,[14] or (c) because it was obtained by misrepresentation or fraud.[15]

In order for a consent to an operation to be valid, it must be the rational act of

a qualified mind. The consent of the patient to the operation is sufficient, if he (a) has attained his majority and (b) is, at the time of giving consent, competent to understand the nature and purpose of the operation proposed and the risks involved. The consent of the husband to an operation on his wife is not necessary; the consent of the wife is sufficient authority.[16] Nevertheless, it is advisable to have the spouse join in the consent whenever practicable. It is particularly desirable to do so if the operation involves danger to life, may destroy or limit sex functions, or may result in the death of an unborn child.

A person who has attained his majority and is of sound mind is presumptively qualified to give or withhold consent.[17] The presumption may be rebutted, however, by evidence showing that when the consent was given the party was drunk,[18] or under the influence of drugs,[19] or delirious or comatose[20] or otherwise incapable of exercising rational judgment. Under such circumstances the law will infer consent if the patient's life was at stake and there was no one present to give consent in his behalf. The fact that a patient is being treated free or at the expense of some one else does not do away with the necessity for obtaining his consent.[21]

In agreeing to perform the operation, the physician does not, in the absence of a special contract, guarantee particular results or to cure.[22] The physician warrants only that he possesses the degree of knowledge and skill ordinarily possessed by a member of the profession in good standing in the community and that he will use that knowledge and skill in the performance of the operation.[23] Although admittedly an unsound practice, a physician may expressly agree to accomplish a particular result or effect a cure. If the physician enters into such a contract and fails to bring about the result or to effect a cure, he is liable for breach of contract even though he used the highest possible professional skill.[24]

Invalid Consent

Consent to a criminal abortion is void because such an operation is unlawful.[25] Consent to an experimental operation that will greatly endanger the life of the patient and which is not intended to relieve or cure his illness or injury, but solely to advance the science and art of medicine, is usually regarded as contrary to public policy and therefore void. In theory, at least, the harm that might be done to society by such experimentation outweigh its possible benefits. Treatment involving an element of experimentation may properly be administered only with the full knowledge and consent of the patient or those legally responsible for him, and then only if the treatment does not vary too radically from the accepted methods of medical practice.

With reference to human experimentation, the House of Delegates of the American Medical Association in 1946 adopted the following statement set forth by the Judicial Council: "In order to conform to the Ethics of the American Medical Association, three requirements must be satisfied in human experimentation (1) the voluntary consent of the person on whom the experiment is to be performed; (2) the danger of each experiment must be previously investigated by animal experimentation, and (3) the experiment must be performed under proper medical protection and management." This statement, of course, assumes the legal prerequisite of therapeutic justification for the treatment undertaken.

An operation for sexual sterilization when such sterilization is not necessary for the cure or prevention of disease or anti-social conduct, is generally regarded as contrary to public policy. This view finds strong support in the widespread legislation forbidding the indiscriminate dissemination of information as to how conception may be prevented and the indiscriminate distribution of devices and preparations designed for that purpose. Consent to a sterilizing operation is therefore probably void unless the operation is intended to cure or prevent disease or antisocial conduct or prevent a pregnancy that would endanger life.[26]

Consent Obtained by Fraud

Purported authority for an operation obtained by misrepresentation or fraud on the part of a physician is not valid authority and affords no protection to the physician.[27] To represent to a patient that an operation is necessary to save life or to preserve health when that is not the case, or that it will give greater relief than there is any reasonable prospect of obtaining, is to perpetuate a fraud on the patient which vitiates his consent. Tactful honesty and frankness on the part of the physician are generally essential.

Minors

Operations on minors, at least on those who have not attained years of discretion, may be lawfully authorized by the parents or, if there is no parent, by a guardian.[28] If the minor has parents, consent should be obtained from them even though the minor is in temporary charge of some other person.[29] In the instance where the parents are legally separated or divorced, consent on behalf of the child should be obtained from the parent who has legal custody. It is particularly important that consent be obtained when the procedure to which the child is to be subjected is for the benefit of some other person, such as a blood or skin donor.[30]

It is not clear whether valid consent to an operation can be given by a child who has not attained his majority, although he is of sound mind and has attained the age of discretion.[31] The fact that such a child is legally qualified to make a contract for medical services as one of the necessities of life may be construed as authorizing him to consent to an operation, at least when the cost is to be paid by him from his own funds.[32] There may be a conflict, however, between the authority of the parent and the authority of the child, especially if a child is under treatment at the expense of his parents. Such conflicts seldom occur, but when they do they must be settled according to the circumstances of the case and the law of the community. In such cases, it is best that the physician refrain from action until the question of authority is settled, unless immediate medical attention is necessary to preserve the health or life of the child.

A man, and in many states a woman also, attains his or her majority on the day before the twenty-first anniversary day of his or her birth.[33] In some states the age of majority for women is eighteen.[34] Presumably, a woman would be regarded, in such states, as having reached her majority on the day before the eighteenth anniversary day of her birth. In some states the marriage of a minor "emancipates" the minor from parental control[35] and may raise a legal question as to the relative rights of the parents or the emancipated minor where one or the other opposes the operation. In such a case the physician should not act without having first obtained the advice of competent legal counsel.

Consent is sometimes withheld by the parents on the ground that such treatment would be contrary to their religious beliefs or because of ignorance. Where the life or health of the child is in jeopardy, it is suggested that the physician or those interested in the child's welfare report the case to the local prosecuting attorney and to any available child welfare agency, with a view to having them initiate immediate legal action.

There are statutes in some states[36] which authorize the juvenile court to order necessary medical and surgical care for a minor whose parent or guardian, when able to do so, refuses to provide it. Pursuant to such statutory authority the courts have issued orders authorizing needed surgical operations[37] and psychiatric examinations,[38] despite the lack of consent on the part of the child's parents.

In other states, courts, acting under the general statutes with respect to neglected and dependent children, have deprived the parents of custody and have appointed guardians authorized to provide necessary attention.[39] Some courts have, however, refused to deprive parents of

custody when they have refused to provide attention or treatment deemed by some to be necessary.[40]

In determining whether to interfere with the parents' right to the custody and control of their child, the courts weigh the danger of the child's condition against the danger of the operation. Blood transfusions have been ordered, over the objections of the parents, for infants afflicted with an Rh complication.[41] The basis for such court action is that there is only negligible danger in the transfusion while, without it, the child will almost surely die or, if it should live, its mental abilities will be greatly impaired. The court refused to order the amputation of a minor's abnormally large arm which was endangering her general health because the operation involved a serious threat to her life.[42]

Incompetents

Where the patient is of unsound mind and incompetent to understand the nature, the purpose and the risks incident to a proposed operation, authority must come, (a) if he is a minor, from one or both of his parents, unless a guardian has been appointed for him by the court, in which case it must come from his guardian; or (b) if he has attained his majority, from his spouse[43] or legally appointed guardian.

An adult not under guardianship who is partially incompetent but sufficiently capable mentally of understanding his need for an operation and the possible consequences may be considered capable of assenting, especially in view of the fact that he is, despite his mental conditions, considered in law to be capable of entering into a contract for medical services as a necessity of life. It is, nevertheless, desirable under such circumstances that a relative, or if there is none, some person who has demonstrated a genuine interest in his care and welfare, approve or join in executing the consent.

When an immediate operation is imperative and the patient is unable to consent rationally to the proposed operation, and when delay incident to the obtaining of the consent of some one legally authorized to consent on behalf of the patient involves serious risk to patient, an operation may be performed on the legal theory of implied consent.[44] The law implies that the patient would, if competent, consent to whatever may be necessary in his own interests. When a surgeon operates under such circumstances he should be prepared to show (a) that an immediate operation was necessary; and (b) that a lawful express consent could not be obtained from the patient or from any person authorized to act for him, without endangering the health or life of the patient.

Limits of Authority

Ordinarily, an operation must be performed within the limits of the authority that has been given.[45] The physician may not perform an operation different from that for which consent has been given.[46] The operation must be performed in the manner which has been agreed upon.[47] A consent must be obtained for each individual operation performed.[48] A consent to one operation will not authorize another or later operation, even though the second operation is for the same condition as the first one.[49] Authority may be given, however, for the operating physician to use his own judgment within certain reasonable limitations. It is usually mutually desirable for the physician to request the patient to allow him a reasonable amount of discretion in the performance of an operation. Even in the case of a limited operation, the operating physician must do whatever may be reasonably necessary for the safety of the patient.[50]

The ordinary legal implication is that if the patient under anesthesia had known beforehand of the circumstances that make a modification or extension of the operation necessary, or if at the moment he could exercise rational judgment, he would give his consent. Since it is assumed that the patient would consent to that which is for his benefit, the law implies consent in such cases. However, a physician may not, in the course of an authorized operation, perform a different operation or unauthorized supplementary surgery unless a true emer

gency exists; there must be a condition which if not corrected would be an imminent threat to life or could result in in grave and irreparable injury to the health of the patient.[51] It is not enough that the physician thinks that certain procedures will be beneficial to the patient. Also the physician must remember at all times that the patient's consent in no way relieves the physician of his duty to exercise due care in all that he does. Consent to the operation does not authorize any deviation from prevailing standards of care and caution.[52]

Implied and Oral Consent

An adult patient of sound mind, who knows that he can agree or refuse to submit to an operation, and who knows or has been fully and fairly informed by his physician as to what is to be done, and who then cooperates with the physician, has impliedly consented even though he has not consented in words.[53] Such implied consent is the consent customarily given in routine office practice. Implied consent to operations always involves the possibility of misunderstanding as to the purpose and scope of the undertaking and the difficulty of obtaining proof in the event of a controversy.

It is under the legal concept of implied consent that a physician is permitted, in an emergency, to operate on or extend the scope of surgery performed on an unconscious or delirious person who is unable to make his own decision.[54] This situation frequently arises in connection with serious accidents when the patient is unable to act for himself. Of course, if some one is present who has authority to act for the patient or if, without jeopardizing the welfare of the patient, such person can be communicated with before operating, his consent should be obtained.

Oral consent to an operation is ordinarily supplemented by implied consent. For instance, a patient, after orally consenting to an operation, cooperates with the physician in its performance. Like implied consent, oral consent is open to misunderstanding and may be difficult of proof.

Written Consent

While written consent to an operation is not required by law,[55] it is desirable in order to avoid the misunderstandings that lead to lawsuits and also to facilitate proof when necessary. The prudent physician will demand a written consent or authorization with respect to any operation which involves an element of recognized danger to the patient or which requires hospitalization.

No particular form is necessary to give validity to a written consent. The essential requirements are that it state clearly the nature and extent of the operation authorized and that it be signed by a person legally qualified to give consent. The authorization should state who is to be responsible for the administering of the anesthetic[56] and the post-operative care[57] of the patient if these services are to be performed by a physician other than the operating surgeon. The inclusion of the place and date of execution and the signature of a witness[58] are desirable, but only because they tend to to facilitate proof.

Generally, the more vague and indefinite the terms of the consent, the more specifically it will be construed by the court.[59] Care should be taken to spell out precisely and in the least technical language possible the exact procedure which the physician intends to perform or the particular condition which he seeks to relieve.

Authorizations and consents should be preserved at least for a sufficient period after the operation to cover the entire time within which, under the statute of limitations, a suit may be instituted. The length of the period of limitations varies from state to state.[60]

Although the performance of an unauthorized operation is technically an assault and battery, it appears that an action for such an operation is sometimes governed by the statute of limitations as to malpractice or personal injury rather than by that as to assault and and battery.[61]

The physician would be wise to retain the authorizations and consents even after the expiration of the limitation period because the holdings of the courts are not uniform on the question of whether the statute begins to run at the time of the doing of the alleged wrongful act or at the time of its discovery.[62] For minors the limitation period does not commence, generally, until the minor has reached his majority.

If a physician requests a written consent to surgery from the patient at the time the arrangements for surgery are made, the patient will be inclined to inquire as to his condition, the nature of the procedure contemplated and the attendant risks. Under these conditions there can be no reasonable allegation by the patient later that he was under sedation when he signed the consent form, or that a hospital attendant had stated that the signing of the consent form was a "mere formality."

Legally, the physician may rely for his authority upon a consent obtained by the hospital for his benefit,[63] but it is readily apparent that the physician may protect himself best by attending to the details of having the consent form, completed, signed and witnessed in his presence.[64] The use of business methods in dealing with this phase of medicine may reduce the number of liability claims that arise from misunderstandings, from the use of poorly drawn or antiquated medicolegal forms or from failure to use written forms.

FOOTNOTES

1. Moos v. United States, 118 F. Supp. 275 (4th Div. Minn., 1954); Church v. Adler, 113 N.E. (2d) 327 (Ill., 1953); Nolan v. Kechijiam, 64 A. (2d) 866 (R.I., 1949); Physicians' and Dentists' Business Bureau v. Dray, 111 P. (2d) 568 (Wash., 1941); Dicenzo v. Berg, 16 A. (2d) 15 (Pa., 1940); Rogers v. Sells, 61 P. (2d) 1018 (Okla., 1936); Mulloy v. Hop Sang. 1 W.W.R. 714 (Atla., 1935); Schmeltz v. Tracy, 177 Atl. 520 (Conn., 1935); Paulsen v. Gundersen, 260 N.W. 448 (Wisc., 1935); Zaman v. Schultz, 19 Pa. D. & C. 309 (1933); Inderbitzen v. Lane Hospital, 12 P. (2d) 744 (Cal., 1932); Moscicki v. Shor, 163 Atl. 341 (Pa., 1932); Donald v. Swann, 137 So. 178 (Ala., 1931); Jackovach v. Yocom 237 N.W. 444 (Iowa, 1931); Franklyn v. Peabody, 228 N.W. 681 (Mich., 1930); Hively v. Higgs, 253 Pac. 363 (Ore., 1927); Hershey v. Peake, 223 Pac. 1113 (Kan., 1924); Throne v. Wandell, 186 N.W. 146 (Wis., 1922); Schloendorff v. Society of New York Hospital, 105 N.E. 92 (N.Y., 1914); Mohr v. Williams, 204 N.W. 12 (Minn., 1905).

2. Schmeltz v. Tracy, 177 Atl. 520 (Conn., 1935). The physician removed moles from the patient's face without her consent. Scars developed where the moles had been removed. The jury found that the scars were the result of intervening acts of the patient, rather than a direct result of the unauthorized operation. The court said, "proof of the assault entitles the plaintiff to a verdict for at least nominal damages."

3. Hively v. Higgs, 253 Pac. 363 (Ore., 1927). The physician had performed an unauthorized tonsillectomy. See, for dicta to the contrary: Tabor v. Scobee, 254 S. W. (2d) 474 (Ky., 1952); Barnett v. Bachrach, 34 A. (2d) 626 (D.C., 1943).

4. Franklyn v. Peabody, 228 N.W. 681 (Mich., 1930); Perry v. Hodgson, 148 S.E. 659 (Ga., 1929); Hershey v. Peake, 223 Pac. 1113 (Kan., 1924); Zoterell v. Repp, 153 N.W. 692 (Mich., 1915); Mohr v. Williams, 104 N.W. 12 (Minn., 1905).

5. See, e.g.: Idaho Code (1948) tit. 66, c. 8; Iowa Code (1954) c. 145; Kan. Gen. Stat. Ann. (1949) c. 76, s. 149-155; Mich. Stat. Ann. (1935) c. 115; N.C. Gen. Stat. (1950) c. 35, s. 36-57; Utah Code Ann. (1953) tit. 64, c. 10.

6. In order for such statutes to be regarded as constitutional, it is necessary that they make provision for notice to the person for whom sterlization is proposed and an opportunity for a full hearing. Brewer v. Valk, 167 S.E. 638 (N.C., 1933); Smith v. Command, 204 N.W. 140 (Mich., 1925).

7. In Smith v. Command, 204 N.W. 140 (Mich., 1925), a sterilization order was set aside because the statutory procedure was not followed.

8. "The state, of necessity, is charged with the proper care of inmates confined in public institutions. If the welfare of an inmate of a public institution demands an operation, we know of no constitutional provision, either state or federal, that prohibits the legislative branch of the government from directing that such operation be performed without the consent or against the will of such inmate." Davis v. Walton, 276 Pac. 921 (Utah, 1929).

9. Valdez v. Percy, 217 P. (2d) 422 (Cal., 1950).

10. Maercklein v. Smith, 266 P. (2d) 1095 (Colo., 1954).

11. In Kinney v. Lockwood, 4 Dom. L.R. 906 (Ont., 1931), the physician did not fully explain to the patient the possible alternative treatments nor advise the patient as to the risks of the operation. In Theodore v. Ellis, 75 So. 655 (La., 1917), the physician failed to explain the object of the operation to the plaintiff or that the same result might possibly be achieved without an operation. See also: Zoterell v. Repp, 153 N.W. 692 (Mich., 1915); Robinson v. Crotwell, 57 So. 23 (Ala., 1911).

12. Hancock v. Hullett, 82 So. 522 (Ala., 1919); Miller v. Bayer, 68 N.W. 869 (Wis., 1896).

13. Christensen v. Thornby, 255 N.W. 620 (Minn., 1934).

14. Moss v. Rishworth, 222 S.W. 225 (Tex., 1920); Mohr v. Williams, 104 N.W. 12 (Minn., 1905).

15. Birnbaum v. Siegler, 76 N.Y.S. (2d) 173 (1948).

16. The rule is, of course, the same where the one to be operated on is the husband and he has given his consent. This rule applies even when it is likely that the operation will have some effect upon the sexual life of the individual, as, for example, in the case of a sterilization operation. Kritzer v. Citron, 224 P. (2d) 808 (Cal., 1950); Barker v. Heaney, 82 S.W. (2d) 417 (Tex., 1935); Rytkonen v. Lojacono, 257 N. W. 703 (Mich., 1934); Burroughs v. Crichton, 48 App. D. C. 596 (1919); State v. Housekeeper, 16, Atl. 382 (Md., 1889).

17. Knowles v. Blue, 95 So. 481 (Ala., 1923); Pratt v. Davis, 79 N.E. 562 (Ill., 1906); Mohr v. Williams, 104 N.W. 12 (Minn., 1905).

18. Barker v. Heaney, 82 S.W. (2d) 417 (Tex., 1935).

19. Wheeler v. Barker, 208 P. (2d) 68 (Cal., 1949); Stone v. Goodman, 271 N.Y. Supp. 500 (1934).

20. Arballo v. Nielson, 166 P. (2d) 621 (Cal., 1946).

21. Bonner v. Moran, 126 F. (2d) 121 (D.C. Cir., 1941).

22. Hawkins v. McCain, 79 S.E. (2d) 493 (N.C., 1954); Waynick v. Reardon, 72 S.E. (2d) 4 (N.C., 1952); Vann v. Harden, 47 S.E. (2d) 314 (Va., 1948); Piper v. Halford, 25 So. (2d) 264 (Ala., 1946); Fritz v. Horsfall, 163 P. (2d) 148 (Wash., 1945); Wall v. Brim, 138 F. (2d) 478 (5th Cir., 1943); Lake v. Baccus, 2 S.E. (2d) 121 (Ga., 1939); Keating v. Perkins, 293 N.Y. Supp. 197 (1937).

23. In Safian v. Aetna Life Insurance Company, 24 N.Y.S. (2d) 92 (1940), the court said: "The honorable member of the medical profession is more keenly conscious than the rest of us that medicine is not an exact science, and he undertakes only to give his best judgment and skill. He knows he cannot warrant a cure."

24. Robins v. Finestone, 127 N.E. (2d) 330 (N.Y., 1955); Colvin v. Smith, 92 N.Y.S. (2d) 794 (1949); Hawkins v. McGee, 146 Atl. 641 (N.H., 1929); Brooks v. Herd, 257 Pac. 238 (Wash., 1927).

25. Martin v. Hardesty, 163 N.E. 610 (Ind., 1928); Milliken v. Heddesheimer, 144 N.E. 264 (Ohio, 1924); Hancock v. Hullett, 82 So. 522 (Ala., 1919); Miller v. Bayer, 68 N.W. 869 (Wis., 1896). Contra: Nash v. Meyer, 31 P. (2d) 273 (Idaho, 1934); Szadiwicz v. Cantor, 154 N.E. 251 (Mass., 1926); Hunter v. Wheate, 289 Fed. 604 (D.C. 1923).

26. Christensen v. Thornby, 255 N.W. 620 (Minn., 1934). The therapeutic justification for the sterilizing operation in this case was that further pregnancies would be dangerous to the health of the plaintiff's wife. The operation was performed on the plaintiff husband because the operation for the sterilization of a male is simpler and less dangerous than that for the sterilization of a female. This

was held to be not contrary to public policy. The operation did not produce sterility in the husband. This suggests that, before a sterilizing operation is performed, the physician and the patient should reach an understanding that the result of such operation is not guaranteed. See also: Wiley v. Wiley, 139 P (2d) 950 (Cal., 1943), in which the court assumes, without discussion, that a nontherapeutic sterilization is a wrongful act.

27. Birnbaum v. Siegler, 76 N.Y.S. (2d) 173 (1948); Keen v. Coleman, 20 S.E. (2d) 175 (Ga., 1942); Haskins v. Howard, 16 S.W. (2d) 20 (Tenn., 1929); Hobbs v. Kizer, 236 Fed. 681 (8th Cir., 1916); Fausette v. Grim, 186 S.W. 1177 (Mo., 1916).

28. Tabor v. Scobee, 254 S.W. (2d) 474 (Ky., 1952); Wells v. McGehee, 39 So. (2d) 196 (La., 1949); Bonner v. Moran, 126 F. (2d) 121 (D.C. Cir., 1941); Zoski v. Gaines, 260 N.W. 99 (Mich., 1935); Jackovach v. Yocom, 237 N.W. 444 (Iowa, 1931); Browning v. Hoffman, 111 S.E. 492 (W.Va., 1922); Moss v. Rishworth, 222 S.W. 225 (Tex., 1920); Luka v. Lowrie, 136 N.W. 1106 (Mich., 1912).

29. Moss v. Rishworth, 222 S.W. 225 (Tex., 1920). Here the consent given by an adult sister, with whom the patient was temporarily living, to the performance of a tonsillectomy on the minor patient, whose parents were living, was held not to be sufficient authorization for the operation.

30. In Bonner V. Moran, 126 F. (2d) 121 (D.C. Cir., 1941), a fifteen year old boy served as a blood and skin donor in a plastic surgery procedure without the consent of his parents. The plaintiff in Zaman v. Schultz, 19 Pa. D. & C. 309 (1933), served as a blood donor without the consent of herself or her parents. It was held, in both cases, that the consent of the parents should have been obtained.

31. The defendant, in Sullivan v. Montgomery, 279 N.Y. Supp. 575 (1935), set the fractured ankle of a patient twenty years and some months old, with the apparent consent of the patient but without the consent of the patient's parents. The operation, said the court, was necessary to stop needless pain and suffering. This was an extremely liberal view of what constitutes an emergency such as would authorize an operation without consent. It is probable that the court was strongly influenced by the facts that the patient was so nearly an adult and that the operation was a relatively minor one. The court, in Bishop v. Shurly, 211 N.W. 75 (Mich., 1926), held that the request of a nineteen-year-old patient that he be given a local anesthetic, even though his mother in making the arrangements for the operation had specified that a general anesthetic was to be given, was a sufficient authorization for the giving of the local anesthetic. In Gulf & Ship Island Railroad Company v. Sullivan, 119 So. 501 (Miss., 1929), the consent of a seventeen-year-old boy to a vaccination was held valid because he had sufficient intelligence to know what he was doing. See also: Bakker v. Welsh, 108 N.W. 94 (Mich., 1906); Lacey v. Laird, 139 N.E. (2d) 25 (Ohio, 1956).

32. Bishop v. Shurly, 211 N.W. 75 (Mich., 1926).

33. Nelson v. Sandkamp, 34 N.W. (2d) 640 (Minn., 1948); Fox v. City of Manchester, 189 Atl. 868 (N.H., 1937); Inhabitants of Town of Gouldsboro v. Inhabitants of Town of Sullivan, 170 Atl. 900 (Me., 1934); Thomas v. Couch, 156 S.E. 206 (Ga., 1930).

34. Alabama, Arkansas, Idaho, Illinois, Montana, Nevada, North Dakota, Oklahoma and Utah.

35. There are statutes providing that marriage emancipates a minor female in Nebraska and Texas. California, Florida, Iowa, Kansas, Louisiana, Oregon and Utah have statutes which provide that marriage emancipates a minor of either sex. It has held in the following cases that marriage emancipates a minor: Inakay v. Sun Laundry Corporation, 42 N.Y.S. (2d) 344 (1943); Kirby v. Gilliam, 28 S.E. (2d) 40 (Va., 1943); La Crosse County v. Vernon County, 290 N.W. 279 (Wis., 1940); in re Palumbo, 14 N.Y.S. (2d) 329 (1939); McWhorter v. Gibson, 84 S.W. (2d) 108 (Tenn., 1935). Contra: Hudson's Guardian v. Hudson, 169 S.W. 891 (Ky., 1914).

36. E.G., Mich. Stat. Ann. (Supp. 1953) s. 27.3178 (598.2) (b) (1) and s. 27.3178 (598.18) (h) and N.Y. Dom. Rel. Ct. Act (McKinney, Supp. 1955) tit. I, s. 2 (17) (g). The New York statute was held constitutional in In re Vasko, 263 N.Y. Supp. 552 (1933). The statute was said to be a valid method by which the state could protect its interest in the health of its infants.

37. In re Rotkowitz, 25 N.Y.S. (2d) 624 (1941); In re Vasko, 263 N.Y. Supp. 552 (1933).

38. In re Carstairs, 115 N.Y.S. (2d) 314 (1952).

39. Morrison v. State, 252 S.W. (2d) 97 (Mo., 1952); People ex rel. Wallace v. Labrenz, 104 N.E. (2d) 769 (Ill., 1952); Mitchell v. Davis, 205 S.W. (2d) 312 (Tex., 1947); Heinemann's Appeal, 96 Pa. 112 (1880).

40. In re Seiferth, 127 N.E. (2d) 820 (N.Y., 1955); In re Frank, 248 P. (2d) 553 (Wash., 1952); In re Hudson, 126 P. (2d) 765 (Wash., 1942); In re Tuttendario, 21 Pa. Dist. R. 561 (Pa., 1912).

41. Morrison v. State, 252 S.W. (2d) 97 (Mo., 1952); People ex rel. Wallace v. Labrenz, 104 N.E. (2d) 769 (Ill., 1952).

42. In re Hudson, 126 P. (2d) 765 (Wash., 1942).

43. Pratt v. Davis, 79 N. E. 562 (Ill., 1906).

44. Wells v. McGehee, 39 So. (2d) 196 (La., 1949); Roger v. Sells, 61 P. (2d) 1018 (Okla., 1936); Jackovach v. Yocom, 237 N.W. 444 (Iowa, 1931); Luka v. Lowrie, 136 N.W. 1106 (Mich., 1912).

45. Rolater v. Strain, 137 Pac. 96 (Okla., 1913). In this case, the patient consented to the defendant's operating on her foot for the purpose of draining an infected wound but instructed the defendant not to remove any bones. The defendant removed the sesamoid bone because the drainage could not be accomplished unless he did so. This was held to be actionable even though there was expert testimony that the sesamoid bone serves no useful purpose.

46. Consent to the performance of a "simple" mastoid operation was held, in Paulsen v. Gundersen, 260 N.W. 448 (Wis., 1935) not to be authority for the performance of a "radical" mastoid operation. In Mohr v. Williams, 104 N.W. 12 (Minn., 1905), it was held that the patient's consent to an operation on her right ear did not authorize the performance of a similar operation on her left ear. See also: Wall v. Brim, 138 F. (2d) 478 (5th Cir., 1943); Perry v. Hodgson, 148 S.E. 658 (Ga., 1929).

47. Frank v. Maliniak, 249 N.Y. Supp. 514 (1931).

48. Keister v. O'Neil, 138 P. (2d) 723 (Cal., 1943). But see Higley v. Jeffrey, 8 P. (2d) 96 (Wyo., 1932), where it was held that consent to an abdominal operation authorized an operation for the removal of a needle left in the abdomen during the surgery; it was held that there was only one continuous operation because the patient was not out from under the anesthetic until the needle had been removed.

49. Pratt v. Davis, 79 N. E. 562 (Ill., 1906).

50. Barnett v. Bachrach, 34 A. (2d) 626 (D.C., 1943); McGuire v. Rix, 225 N.W. 120 (Neb., 1929); Delahunt v. Finton, 221 N.W. 168 (Mich., 1928); King v. Carney, 204 Pac. 270 (Okla., 1922); Harrison v. Reed, 21 Ohio N.P.N.S. 206 (1916); Bennan v. Parsonnet, 83 Atl. 948 (N.J., 1912).

51. Tabor v. Scobee, 254 S.W. (2d) 474 (Ky., 1952); Wall v. Brim, 138 F. (2d) 478 (5th Cir., 1943); Franklyn v. Peabody, 228 N.W. 681 (Mich., 1930); Mohr v. Williams, 104 N.W. 12 (Minn., 1905).

52. Valdez v. Percy, 217 P. (2d) 422 (Cal., 1950).

53. Dicenzo v. Berg, 16 A. (2d) 15 (Pa., 1940); Baxter v. Snow, 2 P. (2d) 257 (Utah, 1931); McCless v. Cohen, 148 Atl. 124 (Md., 1930); Knowles v. Blue, 95 So. 481 (Ala., 1923); Mosslander v. Armstrong 134 N.W. 922 (Neb., 1912); Van Meter v. Crews, 148 S. W. 40 (Ky., 1912).

54. Cases cited notes 44 and 50 supra.

55. Maercklein v. Smith, 266 P. (2d) 1095 (Colo., 1954).

56. A surgeon is not liable for the negligence of an anesthetist who is not performing his duties under the surgeon's direction. Woodson v. Huey, 261 P. (2d) 199 (Okla., 1953); Wiley v. Wharton, 41 N.E. (2d) 255 (Ohio, 1941).

57. In Reed v. Laughlin, 58 S.W. (2d) 440 (Mo., 1933), the surgeon who had performed an appendectomy on the plaintiff failed to give him any post-operative care. The court said: "...as a general rule, in the absence of an agreement or understanding limiting the service, or reasonable notice to the patient that he will not undertake the subsequent treatment, when a surgeon is employed to

perform an operation, the relation of physician and patient continues until ended by the mutual consent of the parties, the physician's withdrawal after reasonable notice, the dismissal of the physician or surgeon by the patient or the cessation of the necessity which gave rise to the relation, and the surgeon must not only use reasonable and ordinary care and skill in performing the operation, but during the continuance of the relation of physician and the patient exercise ordinary diligence in the subsequent treatment and give, or see that the patient is given, such attention as the necessity of the case demands." See also: Saunders v. Lischkoff, 188 So. 815 (Fla., 1939); Gross v. Partlow, 68 P. (2d) 1034 (Wash., 1937); Hopkins v. Heller, 59 Cal. App. 447 (1922).

58. In Wheeler v. Barker, 208 P. (2d) 68 (Cal., 1949) and Stone v. Goodman, 271 N.Y. Supp. 500 (1943), the plaintiff alleged that he signed the consent form while under sedation and that the consent was, therefore, invalid. A witness to the signing testified to the contrary.

59. The court, in Valdez v. Percy, 96 P. (2d) 142 (Cal., 1939), said with respect to a broad, general consent: "However, we do not understand such agreement to constitute a consent to perform operations other than the one for which the operating surgeons were engaged by plaintiff to perform unless necessity therefore arose during the authorized operation as hereinbefore mentioned."

60. The periods of limitations for a malpractice or negligence action range from one to six years; those for an assault and battery action range from one to three years.

61. In Physicians' and Dentists' Business Bureau v. Dray, 111 P. (2d) 568 (Wash., 1941), the court said: "While an unauthorized operation is, in contemplation of law, an assault and battery, it also amounts to malpractice, even though negligence is not charged .... It is stated as a general rule that, in the absence of a special statute of limitations, such actions are controlled 'by the limitations applicable to actions for damages generally.'" See also: Maddox v. Neptune, 264 P. (2d) 1073 (Kan., 1953); McClees v. Cohen, 148 Atl. 124 (Md., 1930); White v. Hirshfield, 236 Pac. 406 (Okla., 1925); Hershey v. Peake, 223 Pac. 1113 (Kan., 1924). There is, however, language in Lewis v. Shaver, 73 S.E. (2d) 320 (N.C., 1952), and Ehlen v. Burrows, 124 P. (2d) 82 (Cal., 1942), which suggests that those courts regard the assault and battery statute as the governing one.

62. It has been held that the statute begins to run at the time of the doing of the wrongful act in Arizona, Colorado, Connecticut, Georgia, Idaho, Illinois, Iowa, Kansas, Kentucky, Maryland, Massachusetts, Missouri, Montana, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Tennessee, Texas, Utah, Vermont, Washington, West Virginia and Wisconsin. In California, Florida, Louisiana and Michigan it has been held that the statute does not begin to run until the time of the discovery of the wrongful act. Arkansas and Indiana have statutes providing that the statute begins to run at the time of the doing of the wrongful act. Title 7, section 25(1) of the Alabama Code Annotated (Supp. 1953) provides: "All actions against physicians and surgeons, and dentists for malpractice, error, mistake or failure to cure, whether based on contract or tort, must be commenced within two years next after the act or omission or failure giving rise to the cause of action, and not afterwards. Provided that if the cause of of action is not discovered and could not reasonably have been discovered within such period, then the action may be commenced within six months from the date of such discovery or the date of discovery of facts which would reasonably lead to such discovery, whichever is earlier, provided further that in no event may the action be commenced more than six years after such act."

63. Keister v. O'Neil, 138 P.(2d) 723 (Cal., 1943).

64. In Stoffberg v. Elliott (Sup. Ct. South Africa, C.G.H., P.D. 1922), S.A.L.R. (1923), C.P.D. 148, the surgeon operated, assuming that the hospital had obtained the patient's consent as it was its custom to do. The hospital had neglected to obtain the patient's consent. The performance of the operation was held a battery.

Form 1.

CONSENT TO OPERATION

PATIENT _____ AGE _____

DATE _____ TIME ____ A.M. / P.M. PLACE _____

1. I hereby authorize Dr. _____ and whomever he may designate as his assistants, to perform upon _____ , the
(State name of patient or "myself")
the following operation: _____; and if any un-
(State nature of procedure(s) to be performed)
foreseen condition arises in the course of the operation calling in his judgment for procedures in addition to or different from those now contemplated, I further request and authorize him to do whatever he deems advisable.

2. The nature and purpose of the operation, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained.

3. I consent to the administration of anesthesia to be applied by or under the direction of Dr. _____, and to the use of such anesthetics as he may deem advisable, with the exception of _____.
(State "none", "spinal anesthesia", etc.)

4. I am aware that sterility may result from this operation although such result has not been guaranteed. I know that a sterile person is incapable of parenthood.

5. I consent to the disposal by authorities of the _____ Hospital of any tissues or parts which may be removed.

6. I consent to the taking and publication of any photographs in the course of this operation for the purpose of advancing medical education.

7. For the purpose of advancing medical education, I also consent to the admittance of observers to the operating room. I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO OPERATION, THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE, AND THAT ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN AND INAPPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN BEEORE I SIGNED.

Signature of patient _____

Signature of patient's husband or wife _____

When patient is a minor or incompetent to give consent:

Signature of person authorized to consent for patient _____

Relationship to patient _____

Witness: _____

Note: This is a general form of consent which will apply to various surgical cases by striking out the portions which are inapplicable. Where the anesthesia is to be administered by a nurse anesthetist, the name of the attending surgeon should be inserted in paragraph 3.

Form 2.

CONSENT TO OPERATION

Date_____

Place_____

1. I hereby consent to and authorize the performance of an operation upon

_____, on or about
(State name of patient or "myself")

_____ 19____, for the following purpose:

_____

_____

The operation is to include whatever procedures are required in attempting to accomplish such purpose. If any conditions are revealed at the time of the operation that were not recognized before and which call for procedures in addition to those originally contemplated, I authorize the performance of such procedures.

2. It is understood that the operation is to be performed at_____

_____, a teaching institution, and will be performed under the

supervision of Dr._____. He is authorized to utilize in the performance of the operation, the services of physicians, residents, or members of the house staff to the extent that he deems them qualified.

3. I hereby authorize Dr._____to prescribe the use of such anesthetics as he may consider advisable, with the exception of

_____
(State "none," "spinal anesthesia," etc.)

4. The nature and purpose of the operation, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no warranty has been made as to the results that may be obtained.

Signed_____
(Patient or person authorized to consent for patient)

Witness_____

Note. This form is intended for use in teaching institutions and primarily for other than private patients. Paragraph 2 is inappropriate where the patient expects or has contracted for the services of a particular surgeon in the performance of the operation. In adapting this form for use, consideration should be given to incorporating some of the provisions contained in Form 1, if they are applicable. To offer an element of choice, different wording is used in expressing some of the provisions which are also contained in Form 1.

Form 3.

CONSENT TO OPERATION FOR COSMETIC PURPOSES

Date_____

Place_____

1. I hereby request and authorize Dr._____to perform an operation upon me on or about the_____day of_____19_____, for the purpose of attempting to improve my appearance with respect to the following condition:_____

_____

2. The effect and nature of the operation to be performed, risks involved, as well as possible alternative methods of treatment, have been fully explained to me.

3. I also authorize the operating surgeon to perform any other procedures which he may deem necessary or desirable in attempting to improve the condition stated in paragraph 1 or any unhealthy or unforeseen condition that he may encounter during the operation.

4. I consent to the administration of anesthetics to be applied by or under the direction of Dr._____, and to the use of such anesthetics as he may deem advisable in my case.

5. I know that the practice of medicine and surgery is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the operation which I have herein requested and authorized.

Signed_____
(Patient or person authorized to give consent for patient)

Witness_____

Form 4.

CONSENT TO OPERATION AND GRAFTING OF TISSUE

Date_____

Place_____

1. I hereby request and authorize Dr._____, and such assistants as he may designate, to perform upon_____,
(Insert "myself" or name of patient.)

the following operation,_____

_____

and to do any other procedure that his judgment may dictate during the above operation.

2. I am informed that the above operation will require the grafting of the following tissue_____, and that the tissue to be used will be supplied by_____.
(Insert name of donor or tissue bank.)

3. The risks involved in the use of such tissue for grafting, the nature and effect of the operation, and possible alternative methods of procedure or treatment have been fully explained to me. No warranty has been made by anyone as to the results that may be obtained.

4. I understand that the operating surgeon will be occupied solely with the surgery, and that the administration of the anesthesia is an independent function and will be in charge of Dr._____, whom I authorize to administer such anesthetics as he may deem advisable.

Signed_____
(Patient or person authorized to give consent for patient)

Witness_____

Form 5

CONSENT TO REMOVAL OF TISSUE FOR GRAFTING

1. I hereby request and authorize Dr._____, and such assistants as he may designate, to perform an operation upon myself for the purpose of removing the following tissues_____ from
(Insert: skin, bone, cartilage, etc.)

my person for donation to_____. The
(Name of recipient or myself)
operation is to include such procedures as may be necessary in the judgment of the operating surgeon for the purpose of attempting to graft tissues, and the use of such anesthetics as he may deem advisable.

2. I make this request with full knowledge that this attempt to graft tissue may not be successful. The risks and uncertainties involved as well as the possibility that I may be permanently injured, scarred, or disfigured as a consequence of this operation, have been fully explained to me. Nevertheless, I make this request and grant the authority set forth above, voluntarily and upon my own initiative, and with no assurances from anyone as to the results that may be obtained, either in respect to myself or the recipient.

Date_____ Signature of Donor_____

The above consent to removal of tissue for grafting was read and signed by the donor in my presence, and in my opinion with complete understanding of its meaning.

Witness_____

Form 6.

CONSENT TO DISPOSAL OF AMPUTATED PART OR ORGAN

I hereby authorize_____
to preserve for scientific purposes, or for use in grafts upon living persons, or to otherwise dispose of the following named tissues, parts, or organs,_____, of

_____ , in a proper and suitable manner.
(Name of patient)

Signed_____

Date_____

Witness_____

Form 7.

STATEMENT OF NEED FOR THERAPEUTIC ABORTION

We find from observation and examination of_____
that she is pregnant, that she is suffering from the following ailment or condition:

_____ , and that it is medically necessary to perform a therapeutic abortion upon her. Further progress of her pregnancy would gravely endanger or imperil her life. We therefore recommend that a therapeutic abortion be performed.

Date_____ (1)_____

(2)_____

(3)_____
Duly licensed physicians.

Note. An abortion is not a crime when performed for therapeutic purposes, that is, when it is necessary to save the life or to preserve the health of the patient. The physician should be in a position to establish the therapeutic grounds upon which he justifies action. In order to best protect himself in this regard, he should obtain and preserve in his file a statement such as the above, signed by at least three reputable physicians (including himself) that they have examined the patient and are of the opinion that an abortion is a medical necessity.

It is strongly urged that the physician read the following section of the Wisconsin Criminal Code, and in particular subsection (5):

"940.04 Abortion. (1) Any person, other than the mother, who intentionally destroys the life of an unborn child may be fined not more than $5,000 or imprisoned not more than 3 years or both.

(2) Any person, other than the mother, who does either of the following may be imprisoned not more than 15 years:

(a) Intentionally destroys the life of an unborn quick child; or

(b) Causes the death of the mother by an act done with intent to destroy the life of an unborn child. It is unnecessary to prove that the fetus was alive when the act so causing the mother's death was committed.

(3) Any pregnant woman who intentionally destroys the life of her unborn child or who consents to such destruction by another may be fined not more than $200 or imprisoned not more than 6 months or both.

(4) Any pregnant woman who intentionally destroys the life of her unborn quick child or who consents to such destruction by another may be imprisoned not more than 2 years.

(5) This section does not apply to a therapeutic abortion which:

(a) Is performed by a physician; and

(b) Is necessary, or is advised by 2 other physicians as necessary, to save the life of the mother; and

(c) Unless an emergency prevents, is performed in a licensed maternity hospital.

(6) In this section "unborn child" means a human being from the time of conception until it is born alive."

Section 966.20, Wisconsin Statutes, 1955, requires physicians, hospitals and others having knowledge of the death of any person following an abortion to report such death immediately to the sheriff, police chief, or coroner of the county wherein such death took place.

The importance of a full statement by the patient to the physician is well illustrated by a Wisconsin case. In State v. Law (1912), 150 Wis. 313, a physician called to treat a woman after an abortion refused to take charge of her unless she made a full statement concerning the abortion, which he insisted upon for his own protection and to enable him to institute proper treatment. The Supreme Court of Wisconsin said: "It was a very proper request for him to make under the circumstances." Thus there is judicial recognition, by the highest court in Wisconsin, that it is proper for a physician to take precautionary steps to protect himself in such a situation.

Form 8.

AUTHORIZATION TO TREAT CONDITION OF RECENT OR PARTIAL ABORTION

Date_____

I hereby authorize Dr._____

to treat me for the condition set forth in the following history:_____

_____

_____

_____

This condition occurred prior to the time that I visited Dr._____

_____for treatment.

Signed_____

Witness_____

Note. If the patient is able to do so, it is desirable that she set forth the history of her condition in her own words and handwriting in the space provided therefor. It is also desirable that her husband, or if she is not married, a parent, should sign as a witness.

Form 9.

CONSENT TO OFFICE TREATMENT

I, having been fully informed by Dr._____

of the risks and possible consequences involved in treatment by means of_____

_____ for the relief of_____

_____, nevertheless

hereby authorize Dr._____to administer such treatment

to me, and agree to hold him free and harmless for any claims, or suits for damages for any

injury or complications whatever which may result from this treatment.

Signed_____

Date_____

The foregoing consent wos reod, discussed, ond signed in my presence, ond in my opinion the person so signing did so freely with full knowledge ond understonding.

Witness_____

Note. This is a general form of consent that is intended for use, primarily, in connection with the administration of hazardous drugs and treatment normally provided in the physician's office.

Form 10.

CONSENT TO X-RAY THERAPY

PATIENT_____ AGE_____

DATE_____ TIME_____ A.M. P.M. PLACE_____

I hereby request and authorize Dr._____

and whomever he may designate to assist him to administer X-ray treatment to_____

_____ and to continue such treatment from time to
(Name of patient or "myself")

time as he may deem advisable. The effect and nature of this treatment have been fully explained to me, as well as the possibility of injury. Notwithstanding the fact that there are risks of injury inherent in this treatment, I voluntarily accept the risks involved.

Signed_____

The foregoing consent was read, discussed, and signed in my presence, and in my opinion the person so signing did so freely with full knowledge and understanding.

Witness_____

Note. The liability of a physician for injuries caused by the use of an X-ray machine rests upon the same principles of law as does liability in any other branch of medicine or surgery. Generally, he is liable if injury results from his failure to possess or use that degree of skill or care ordinarily possessed by reputable physicians in the same locality, or in similar localities, engaged in this type of work. Facer v. Lewis, 40 N.W. (2d) 457 (Mich., 1950); Nance v. Hitch, 76 S.E (2d) 461 (N.C., 1953); Simon v. Kaplan, 52 N.E. (2d) 832 (Ill., 1944). A patient in submitting to an exposure to X-ray, assumes the risk that, because of a personal idiosyncracy, he will suffer a burn even though due care and skill is used by the physician. Ballance v. Dunnington, 217 N.W. 329 (Mich., 1928); Rost v. Roberts, 192 N.W. 38 (Wis., 1923); Stemons v. Turner, 117 Atl. 922 (Pa., 1922); Antowill v. Friedmann, 188 N.Y. Supp. 777 (1921); Runyan v. Goodrum, 228 S.W. 397 (Ark., 1921). In signing this form, the patient does not agree to assume the risk of injury caused by the physician's negligence in the use of X-ray; such an agreement is contrary to public policy. Hales v. Raines, 141 S.W. 917 (Mo., 1911).

Form 11.

CONSENT TO ELECTROSHOCK THERAPY

Date_____

Having been fully informed of its nature and purpose I (We) hereby request and authorize Dr._____, or his designee, to administer electroshock therapy to_____, a patient in the_____
(Name of patient or "myself")
Hospital. I (We) also agree to hold the Hospital, all of its officers and employees, and the attending physicians free from liability for any injury, including but not limited to fractures and dislocations, which may result from such treatment. No assurance has been made by anyone with respect to the results that may be obtained.

Signed_____

Signed_____

The foregoing consent was read, discussed, and signed in my presence, and in my opinion the person so signing did so freely with full knowledge and understanding.

Witness_____

Note. In the course of electroshock therapy, injury may occur even though the highest degree of skill and care is used. Severe convulsions are produced in the patient which may cause the patient to suffer a fracture no matter what precautions are observed. Under these circumstances the physician is not liable for damages. Farber v. Olkon, 254 P. (2d) 520, (Cal., 1953); Quinley v. Cocke, 192 S.W. (2d) 992 (Tenn., 1946).

DRIVERS' LICENSES FOR EPILEPTICS

A person subject to epileptic seizures may be licensed to drive a motor vehicle in Wisconsin on a temporary basis if:

1. He is recommended for a temporary license by any physician licensed in Wisconsin.
2. He is under medical care.
3. While under medication he is free from seizures.
4. His driving is not otherwise a hazard to public safety.
5. His physician recertifies each six months that he is free from seizures.

The physician makes his certification on a combined questionnaire and recommendation form provided by the Motor Vehicle Department. The physician making such a recommendation must be the physician who is rendering treatment to the epileptic patient. The issuance of a temporary license is discretionary with the Motor Vehicle Department. A denial may be reviewed, however, by a special board of five members. Four of these members are designated by the president of the State Board of Health.**

Reference: *Section 343.09, Wisconsin Statutes, 1957.*

** The fifth member is the Commissioner of the Motor Vehicle Department, and he and any two of the other members constitute a quorum.

Form 12.

EXPLANATION OF ELECTROSHOCK THERAPY FOR PATIENT, PARENT OR LEGAL REPRESENTATIVE

Electroshock therapy is an accepted form of treatment for certain types of nervous and mental illness. It has been used successfully in thousands of cases since its introduction in 1938. It is one of the most effective ways of treating depressed patients with suicidal tendencies or patients who might otherwise require prolonged hospitalization.

The psychiatrist himself gives the treatment, using a specially designed electronic instrument. The treatment consists of passing a controlled electric current between two electrodes applied to the patient's temples. In some instances, the patient may be given medication prior to treatment to reduce tension and produce muscular relaxation. The patient experiences no discomfort or pain during the treatment; he does not feel the electric current and has no memory of the treatment. When the treatment is given, the patient becomes immediately unconscious and has strong muscular contractions of a convulsive nature. These contractions last 35 to 50 seconds. Complete relaxation follows and several minutes later the patient gradually regains consciousness. His condition is similar to that of a patient emerging from brief anesthesia. Within 15 to 60 minutes, the confusion clears and the patient is able to recognize his surroundings. Following this, the patient is permitted to get up and about. Headache and nausea sometimes occur, but these are infrequent and usually respond rapidly to simple treatment.

The number of treatments in any given case will vary with the condition being treated, and the individual response to treatment. The frequency of treatment will also vary with each case. As the treatments progress (usually after the 3rd and 4th treatment), a certain amount of haziness of memory and confusion develops. This memory impairment is transitory and usually clears up within several weeks following the last treatment.

Electroshock therapy, like any other medical or surgical procedure involves a certain amount of calculated risk. Complications are infrequent, the most common being fractures and dislocations of the extremities, or fractures of the vertebrae. These may sometimes occur, in spite of all precautions and must be looked upon as a recognized hazard of the treatment. Should such an injury occur, the patient and his family will be notified and urged to call in a physician competent to treat the complication.

During the hospital treatment, the patient's general care is provided by the hospital personnel. On discharge from the hospital, the patient begins a "convalescent period" of several weeks duration during which he must be under strict supervision of some member of the family or some responsible person selected by the family. This precaution is necessary because of the temporary mental confusion and impairment of memory. During this entire period, the patient is not permitted to drive an automobile, to transact any business or to carry on his usual employment until the doctor gives his permission. He should not be permitted to leave the house unless accompanied by a responsible companion because of the possibility that he may wander off and get lost. Supervision is very important and must be provided by a responsible person.

Finally, a word about the results of treatment. Although the results in most cases are gratifying, not all cases will respond equally well. As in all forms of medical treatment in general, some patients will recover promptly; others will recover only to relapse again and require further treatment; still others may fail to respond at all.

The above information has been prepared to answer some of the most frequently asked questions concerning electroshock therapy. The treating psychiatrist will be glad to answer any further questions which may occur to the patient or his family.

When the patient is treated by the ambulatory or outpatient method the family, or someone designated by the family, has definite and real responsibility for the patient's care. The patient is escorted to the hospital or the doctor's office. The responsible person stays with the patient until he reacts from the treatment and then escorts him back home. During the approximately two-week period of treatment and for at least two or three weeks following termination of treatment the patient must be under the strict supervision and companionship of the family.

ACKNOWLEDGMENT OF READING

Date_____

I,_____, hereby acknowledge receipt and understanding of this information sheet which contains details relative to the care, risks, and treatment to be received by_____

Witness_____ Signed_____

Note. Acknowledgement is made to Drs. Isadore Rodis and Robert H. Groh of Washington, D.C., for the use of this form. A copy of this form is signed by the patient or the person responsible for the patient and is retained by the physician, and another copy is given to the patient or the responsible party. As in the case of all forms, this form should be modified to conform with the actual circumstances of treatment. Furthermore, a specific consent form, such as Form 11, should also be used together with this form as an additional safeguard.

It is recommended that physicians employing electroshock therapy have the preceding information sheet mimeographed or printed for the use of patients, parents, or guardians.

Form 13.

CONSENT TO SHOCK THERAPY

PATIENT_____AGE_____

DATE_____TIME_____ A.M. P.M. PLACE _____

I (We) hereby request and authorize Dr._____ and whomever he may designate to assist him to administer_____ shock therapy to _____; and to continue to administer shock therapy and such other supplemental treatment as he may deem advisable from time to time. The effect and nature of shock treatment have been fully explained to me (us), as well as the hazards involved. Notwithstanding the fact that there are risks of injury to the patient inherent in this treatment, I (we) voluntarily accept the risks involved.

Signed_____

Signed_____

The foregoing consent was read, discussed, and signed in my presence, and in my opinion the person so signing did so freely with full knowledge and understanding.

Witness_____

Note. This form may be used either in connection with insulin or electroshock therapy.

Form 14.

PERMISSION TO USE RADIOISOTOPES

Date_____

1. I hereby request and authorize Dr._____, and whomever he may designate to assist him to administer a (tracer) (therapeutic) dose of_____ _____to me.

2. The nature of this treatment as well as the risks and uncertainties involved have been fully explained to me. I understand that Dr._____, his assistants, the Hospital, its agents and its personnel assume no responsibility for the results or effects of this study nor its interpretation.

Signed_____

The foregoing consent was read, discussed, and signed in my presence, and in my opinion the person so signing did so freely with full knowledge and understanding.

Witness_____

Form 15.

CONSENT TO DIAGNOSTIC PROCEDURE

PATIENT_____AGE _____

DATE_____TIME _____ A.M. P.M. PLACE_____

I hereby request and authorize Dr. _____and whomever he may designate to assist him to perform upon_____the
(Name of patient or "myself")
following diagnostic procedure:_____.

I have been fully informed of the risks and possible consequences involved and that unforeseen results may occur.

Signed_____

The foregoing consent was read, discussed, and signed in my presence, and in my opinion the person so signing did so freely and with full knowledge and understanding.

Witness_____

Form 16.

AGREEMENT FOR BLOOD TRANSFUSION

To: Dr._____
(Attending physician)

and_____ Hospital Date_____ 19____

1. I hereby request and authorize the administration of a blood transfusion to_____

_____ and such additional transfusions as may be deemed
(Insert "myself" or name of patient)
advisable in the judgment of Dr._____ , the attending physician, or

those he may designate to assist him.

2. It is understood and agreed that the attending physician or his assistants will be responsible only for the performance of their own individual professional acts, and that the blood typing and the selection of compatible blood are the responsibilities of those who actually perform the necessary laboratory tests.

3. It has been fully explained that blood transfusions are not always successful in producing a desirable result and that there is a possibility of ill-effects such as the transmission of infectious hepatitis or other diseases or blood impairments.

4. Also, it has been explained that emergencies may arise when it may not be possible to make adequate cross-matching tests, and that immediate need may make it necessary to use existing stocks of blood which may not include the most compatible blood types.

5. It is understood and expressly agreed that the blood supplied in accordance with this agreement is incidental to the rendition of services and that no requirement, guarantee, or warranty of fitnes or quality shall apply.

Signature of patient_____

When patient is a minor or incompetent to give consent:

Signature of person authorized to

consent for patient_____

Address_____

Relationship to patient_____

Witness: Signature_____

Address_____

City and State_____

Note. In Perlmutter v. Beth David Hospital, 123 N.E. (2d) 792 (N.Y., 1954), the plaintiff became ill with jaundice after receiving a blood transfusion while a patient at the defendant hospital. The hospital charged her $60 for this blood. The plaintiff alleged in her complaint that the blood was responsible for her illness and that the hospital had breached implied warranties of fitness and merchantability in providing contaminated blood. In a 4-to-3 decision the court held that the supplying of blood by the hospital was not a sale but merely an incident of an entire contract for services to which implied warranties do not attach. Because the decision is a close one which other courts may not choose to follow, paragraph 5 of the above form is intended as a specific contractual provision to the effect that the quality of the blood furnished is not guaranteed. Such provisions will probably offer no protection in a situation where there is negligence, such as contamination due to the improper storage of blood.

Form 17.

AGREEMENT FOR BLOOD PLASMA TRANSFUSION

To: Dr._____
(Attending physician)
and_____ Hospital Date_____19_____.

1. I hereby request and authorize the administration of blood plasma to_____
_____in such amounts and at such times as may be deemed
(Insert "myself" or name of patient)
advisable in the judgment of Dr._____, the attending physician, or those he may designate to assist him.

2. It has been fully explained that blood plasma is a product manufactured from pooled blood of many donors and sometimes carries the virus of infectious hepatitis and other diseases. It has been further explained that the administration of blood plasma is not always successful in producing a desirable result.

3. It is understood and expressly agreed that the blood plasma supplied in accordance with this agreement is incidental to the rendition of services and that no requirement, guarantee, or warranty of fitness or quality shall apply.

Signature of patient_____

When patient is a minor or incompetent to give consent:

Signature of person authorized to consent for patient_____

Address_____

Relationship to patient_____

Witness: Signature_____

Address_____

City and State_____

Form 18-A.

AGREEMENT WITH BLOOD DONOR

To: Dr. _____
(Physician in charge of blood bank)
and _____ Hospital Date _____ 19____.

1. On behalf of _____, a patient who has been the recipient of blood from the blood bank of the _____ Hospital, and in order to reduce the obligation which was incurred by this patient in receiving such blood, I request that I be accepted as a blood donor.

2. I represent that I am not now nor have I ever been afflicted with syphilis, tuberculosis, malaria, infectious hepatitis, brucellosis, infectious mononucleosis or any other infectious disease or blood impairment, except as stated in paragraph 3. I am in good health and know no reason or condition which might impair or affect the suitability of my blood or create a danger in any way for the recipient of my blood; nor do I know of any condition, physical or mental, which might impair my own health and well-being as a result of my serving as a blood donor.

3. The following are all the infectious diseases or blood impairments which I have ever had:

_____

_____

4. In consideration of the sum of _____ dollars ($_____) to be paid me for my services as a blood donor, which I direct you to apply against the bill for services due and owing by the patient referred to in paragraph 1, I agree to assume all of the direct and indirect risks involved, including but not limited to personal injuries which I may sustain.

5. I have been given, understand, and agree to follow the precautionary instructions which are intended to facilitate my own recovery after giving blood. I have also been informed of the possibility of ill-effects and the risks involved in serving as a blood donor.

6. The last time that I served as a blood donor was on _____ 19____.
I HEREBY SWEAR THAT ALL OF THE ABOVE STATEMENTS ARE TRUE AND CORRECT AND THAT I FULLY UNDERSTAND THE MEANING OF THIS AGREEMENT.

Signed _____

Address _____

City and State _____

Witness _____
ACCEPTED:
Dr. _____

and _____ Hospital

By _____
(Duly authorized agent)

Note. This form of "Agreement with Blood Donor" is intended to be used where the donor is providing blood for a relative or a friend. It should be executed prior to the taking of blood.

Form 18-B.

RELEASE AND RECEIPT (BLOOD DONOR)

I hereby acknowledge receipt of the sum of_____dollars ($_____),

which I direct you to apply against the bill for services due and owing by_____

_____, the patient on whose behalf I have given my blood, and in consideration therefor

I hereby and forever release Dr._____ and_____
(Physician in charge of blood bank)
Hospital and their agents, employees and assistants from all liability of whatsoever nature, whether for personal injuries or in tort or in contract, in connection with or resulting from the services that I have already rendered, and I am now leaving the premises at my own request.

I FULLY UNDERSTAND THAT THIS IS A COMPLETE RELEASE OF ALL MY CLAIMS.

Signed_____

Date_____19_____.

Witness_____

Note. Although a release signed before the taking of blood is of no value, a release signed after the taking of blood, for valuable consideration, may possibly be of substantial value in many instances.

SALE OF CONTRACEPTIVES AND ABORTIFACIENTS

The sale of contraceptives and abortifacients or articles appropriate to that use and sold with the intention that they be so used, is prohibited by Section 151.15 of the Wisconsin Statutes to all persons other than a physician or pharmacist duly licensed in this state. In no event may such article, drug, or preparation be sold to any unmarried person.

Prohibited also is the advertising or displaying of such articles for sale, or the manufacture, purchase or possession of a machine or device appropriate for vending contraceptives or abortifacients.

Violation of the provisions of this statute subjects the violator to a fine of not less than one hundred dollars ($100.00), or imprisonment in a county jail for not to exceed six months.

Form 19-A.

AGREEMENT WITH BLOOD DONOR

To: Dr. _____
(Physician in charge of blood bank)

and _____ Hospital Date _____ 19____.

1. I represent that I am not now nor have I ever been afflicted with syphilis, tuberculosis, malaria, infectious hepatitis, brucellosis, infectious mononucleosis or any other infectious disease or blood impairment, except as stated in paragraph 2. I am in good health and know no reason or condition which might impair or affect the suitability of my blood or create a danger in any way for the recipient of my blood; nor do I know of any condition, physical or mental, which might impair my own health and well-being as a result of my serving as a blood donor.

2. The following are all the infectious diseases or blood impairments which I have ever had: _____

_____

3. In consideration of the sum of _____ dollars ($_____) to be paid me for my services as a blood donor, I agree to assume all of the direct and indirect risks involved, including but not limited to personal injuries which I may sustain as a result of the taking of my blood.

4. I have been given, understand, and agree to follow the precautionary instructions which are intended to facilitate my own recovery after giving blood. I have also been informed of the possibility of ill-effects and the risks involved in my serving as a blood donor.

5. The last time that I served as a blood donor was on _____ 19____.
I HEREBY SWEAR THAT ALL OF THE ABOVE STATEMENTS ARE TRUE AND CORRECT AND THAT I FULLY UNDERSTAND THE MEANING OF THIS AGREEMENT.

Signed _____

Witness _____

Address _____

ACCEPTED:

City and State _____

Dr. _____

and _____ Hospital

By _____
(Duly authorized agent)

Note. This form of "Agreement with Blood Donor" is intended to be used for professional blood donors.

Form 19-B.

RELEASE AND RECEIPT (BLOOD DONOR)

I hereby acknowledge receipt of the sum of _____ dollars ($ _____)

in hand paid, and in consideration therefor I hereby and forever release Dr. _____

_____ and _____ Hospital
(Physician in charge of blood bank)

and their agents, employees and assistants from all liability of whatsoever nature, whether for personal injuries or in tort or in contract, in connection with or resulting from the services that I have already rendered, and I am now leaving the premises at my own request.

I FULLY UNDERSTAND THAT THIS IS A COMPLETE RELEASE OF ALL MY CLAIMS.

Signed _____

Date _____ 19_____.

Witness _____

Note. The "Release and Receipt (Blood Donor)" should be signed after the taking of blood and at the time the donor is paid.

STERILIZATION

The sterilization of individuals, for other than therapeutic reasons, is undoubtedly limited in Wisconsin to those cases specifically authorized by statute. An institutionalized criminal or mentally diseased person, under Sec. 46.12 Stats., may be sterilized provided that the elaborate precautions set forth in that statute are followed.

A physician who sterilizes a person for any but clearly therapeutic reasons may be guilty of performing an illegal operation. For that reason it is recommended that additional physicians be called in consultation to determine the therapeutic advisability of the procedure.

The illegal character of any but a therapeutic sterilization would not be altered because the patient or his representative consented in writing to the operation.

CHAPTER II

PATIENT'S RIGHT TO PRIVACY

In recent years there has been a trend among the courts to provide a remedy, in the form of an action in tort, for the violation of an individual's right of privacy. The individual has a right to be "left alone" and not be subject to unwarranted and unwanted publicity, with possible attendant shame, mortification and humiliation.

A patient has the same right of privacy that any other individual has. He has a right to have information relating to his condition kept secret and not made the subject of publicity.[1] When a patient disrobes for an examination, operation or any other medical procedure, he does so for the professional benefit of the physician and he does not expect to be subjected to the examination of other persons, medical or non-medical, who are not necessary to the carrying out of the medical procedure. The admission of non-essential persons, without the specific consent of the patient, constitutes a violation of the patient's right of privacy.[2] Nor does the patient, when he submits to a medical procedure, consent to the taking of his picture for future publication.

The unauthorized taking of pictures of the patient, even though they have not been published, will give rise to a cause of action.[3] One of the most frequent violations of a patient's right of privacy is the unauthorized use of his picture.[4] It is immaterial that the patient's condition is made public because it is newsworthy and of interest to the public[5] or that unessential persons are permitted to observe the patient or that pictures of the patient are taken and published for the purpose of advancing medical science[6] or educating the public.

The Attorney General of New York made the following answer to the State Department of Health's question whether it could, legally, present an educational exhibit of "before and after" pictures of cancer patients at the state fair: "It is my opinion that you may not legally make use of these photographs for the purpose of public display as set forth in your letter, without the consent of the subjects of the photographs, if they are of living persons. While it is true that the contemplated use may have a distinct social value for the general instruction and information of the public, yet I believe that the unauthorized use of such pictures is barred by the provisions of the statute. . . . The unfortunate person afflicted with a malignent disease such as cancer may very well have a perfectly natural and readily understandable aversion to having a photograph or picture showing his condition displayed before the public."[7]

Publicity may be given to the patient's condition, observers may be admitted and pictures may be taken and published only if specifically consented to by the patient. To facilitate proof, if such should become necessary, the consent should be in writing. It should state specifically just what it is that the patient consents to with respect to observers, pictures, etc. If there are any restrictions or limitations on the consent they must be strictly observed.[8]

Thus far Wisconsin has not developed any law by way of statute or court decision which is concerned exclusively with an individual's right to privacy. The indications from decisions of the Wisconsin supreme court to date are that the courts of this state do not recognize a right to privacy in an individual, in the sense of a right enforceable by the courts, unless the person asserting that he has been damaged has a legal basis for enforcing such claim independent of the alleged invasion of his privacy.

FOOTNOTES

1. The publication of a news story about the patient's unique ailment, which story included the patient's name and picture, was held, in Barber v. Time, Inc., 159 S.W. (2d) 291 (Mo., 1942), to be a violation of the patient's right of privacy. See also: Bazemore v. Savannah Hospital, 155 S.E. 194 (Ga., 1930).

2. In DeMay v. Roberts, 46 Mich., 160 (1881), the physician took a young, unmarried man, who was not a doctor, to the plaintiff's confinement. This was held to be actionable. The defendant, in Carr v. Shifflett, 82 F. (2d) 874 (D.C. Cir., 1936), had a layman perform a cauterization on the plaintiff. The case was tried on the theory that there was negligence in the doing of the cauterization. Judgment was for the defendant but it was suggested, in both the court's opinion and a concurring opinion, that the plaintiff could have had a cause of action for the exposure of her body to one who was not a doctor. See also: Savage v. Boies, 272 P. (2d) 349 (Ariz., 1954).

3. Clayman v. Bernstein, 38 Pa. D. & C. 543, 548 (1940). The court said: "While the court appreciates the development of the art of photography generally, and in the medical profession particularly, not only as a means of diagnois and treatment, but also as a means of instruction, its progress has not yet reached a stage at which physicians have been accorded the right to photograph their patients without their consent, nor has medical jurisprudence recognized the unlimited right of a physician to perform any test, administer any treatment, or perform any operation without the authority of the patient."

4. Barber v. Time, Inc., 159 S.W. (2d) 291 (Mo., 1942); Banks v. King Features Syndicate, 30 F. Supp. 352 (S.D.N.Y., 1939); Griffin v. Medical Society of State of New York, 11 N.Y.S. (2d) 109 (1939); Bazemore v. Savannah Hospital, 155 S.E. 194 (Ga., 1930).

5. Barber v. Time, Inc., 159 S.W. (2d) 291 (Mo., 1942).

6. Clayman v. Bernstein, 38 Pa. D. & C. 543 (1940).

7. N.Y. Att'y. Gen. Rep. (1934) 374.

8. Feeney v. Young, 181 N.Y. Supp. 481 (1920). The plaintiff had consented to the taking of motion pictures of a Caesarean performed on her which were to be exhibited for scientific purposes only. Publicly showing these pictures, as a part of a film called "Birth," was held actionable.

9. In Stone v. Eisen, 114 N.E. 44, 45 (N.Y., 1916), the court said: "Decent and respectful treatment is implied in the contract from the confidential relation of the parties and especially because of the necessary exposure of the person required of the patient in connection with the services to be performed pursuant to the contract. The implication arises whenever one person is placed in the control or protection of another." See also, Inderbitzen v. Lane Hospital, 12 P. (2d) 744 (Cal., 1932), where the pregnant patient was subjected to some thirty or forty examinations by medical students to the accompaniment of levity and discourtesy.

Form 20.

AUTHORITY TO ADMIT OBSERVERS

PATIENT'S NAME _____ AGE _____ DATE _____

I hereby grant authority to Dr. _____ and to

_____ Hospital to permit the presence of such observers as they may deem fit to admit in addition to physicians and hospital personnel, while I am undergoing (operative surgery) (childbirth), examination, and treatment.

Signed _____

Witness _____

NOTE: The addition of the signature of the patient's spouse, or, in the case of a minor or incompetent, the substitution of a signature of a parent or legal guardian is desirable in assuring legal protection to the physician.

Form 21.

CONSENT TO TAKING OF PHOTOGRAPHS

In connection with the medical services which I am receiving from Dr. _____, I consent that photographs may be taken of me or parts of my body, under the following conditions: (1) The photographs may be taken only with the consent of my physician or surgeon and under such conditions and at such times as may be approved by him. (2) The photographs shall be taken by my physician or by a competent photographer, approved by my physician. (3) These photographs shall be used for medical records only, unless, in the judgment of my physician, medical research, education, or science will be benefited by their use. In that event I agree that they may be used for such purposes, provided that my identity is not revealed by the photographs or by descriptive texts accompanying them.

_____ M.D.

_____
(Patient)

_____
Witness

_____
(Parent or Legal Guardian)

NOTE: The addition of the signature of the patient's spouse, or, in the case of a minor or incompetent, the substitution of a signature of a parent or legal guardian is desirable in assuring legal protection to the physician.

Form 22.

CONSENT TO PUBLICATION OF PHOTOGRAPHS

PATIENT _____ PLACE _____ DATE _____

1. I hereby authorize Dr. _____ and such assistants, photographers, and technicians as he may engage for this purpose, to take such photographs of me as he may desire before, during, and after the operation which is to be performed upon me on or about _____ 19____, and to permit such photographs to be published and republished in professional journals and medical books or to be used for any other purpose which he may deem fit in the interest of medical education, knowledge or research.

2. Authority is further given to permit the modification or retouching of the aforementioned photographs, and to the publication of information relating to my case, either separately or in connection with the publication of the photographs taken of me.

3. Although I give permission to the publication of all details and photographs concerning my case, it is specifically understood that I will not be identified by name.

Signed _____

Witness _____

NOTE: The addition of the signature of the patient's spouse, or, in the case of a minor or incompetent, the substitution of a signature of a parent or legal guardian is desirable in assuring legal protection to the physician.

Form 23.

CONSENT TO TELEVISING OF OPERATION

PATIENT _____ PLACE _____ DATE _____

In the interest of medical education and knowledge, I hereby consent to the televising of the operation which is scheduled to be performed upon me on or about _____ 19____. I hereby authorize Dr. _____ and the _____ Hospital to admit to the operating room, the cameramen and technicians who are to participate in the televising of this operation, in addition to the usual hospital staff.

Signed _____

Witness _____

NOTE: The addition of the signature of the patient's spouse, or, in the case of a minor or incompetent, the substitution of a signature of a parent or legal guardian is desirable in assuring legal protection to the physician.

Form 24.

CONSENT TO TAKING OF MOTION PICTURES OF OPERATION

PATIENT_____ PLACE_____DATE _____

1. I hereby consent to the taking of motion pictures of the operation which is scheduled to be performed upon me on or about _____ 19___. I authorize Dr. _____ and the _____ Hospital to admit to the operating room the cameramen and technicians who will participate in the filming of this operation.

2. I hereby and forever waive all rights that I may have to any claims for payment or royalties in connection with any exhibition, televising, or other showing of this motion picture film, regardless of whether such exhibition, televising, or other showing is under philanthropic, commercial, institutional, or private sponsorship, and irrespective of whether a fee of admission or film rental is charged.

3. I grant this consent as a voluntary contribution in the interest of medical education and knowledge and subject only to the condition that I will not be identified by name in this motion picture film.

Signed _____

Witness_____

NOTE: The addition of the signature of the patient's spouse, or, in the case of a minor or incompetent, the substitution of a signature of a parent or legal guardian is desirable in assuring legal protection to the physician.

CHEMICAL TESTS FOR INTOXICATION

Chemical tests for intoxication are legal in Wisconsin.

Samples of breath, blood, urine, or saliva may be taken and analyzed to determine the sobriety of a person operating a vehicle or handling a firearm. The results of the analyses are admissible as evidence in court cases and other legal proceedings.

Sobriety will be deemed proved—if a sample taken within two hours of the event shows only 5 one-hundredths of 1% or less by weight of alcohol in the blood. Other evidence to the contrary may affect or change the presumption, however.

Intoxication will be presumed—if the alcohol concentration is 15 one-hundredths of 1% or more. Other contrary evidence may upset this presumption.

No presumption is created—by alcohol concentrations between these two ratios, or if the sample was taken more than two hours after the event. However, an expert witness may testify that even these tests prove sobriety or intoxication.

Chapter III

CONFIDENTIAL COMMUNICATIONS AND RECORDS

The relation between a physician and his patient is an extremely confidential one. The patient should feel free to make a full disclosure of fact to his physician, in order that the physician may most effectively render his services, and the patient should be free to make this disclosure with the knowledge that the physician will respect the confidential nature of the communications. It is a breach of professional ethics for the physician to reveal the confidential communications of his patients without the express consent of the patient, unless required by law, as in the case of communicable diseases. The betrayal of a patient's confidence may also be grounds for revocation of the physician's license.[1] The physician should, therefore, obtain the express written consent of the patient before releasing confidential information.

Confidential communications between physician and patient have the statutory status of privileged communications in some states.[2] In states where communications have this status, the physician may not testify in a judicial or administrative proceeding as to information obtained as a result of the physician-patient relationship.

The privilege also extends to hospital records insofar as they tend to disclose what the physician learned in the course of treatment.[3] Generally, it has been held that where a physician is employed by an insurance company or other adverse party to examine a claimant, with no contemplation of any treatment, the information thus acquired is not privileged and the physician may testify as to such information.[4]

In order for privilege to apply, it is not necessary that any treatment shall actually have been given; all that is necessary is that the information shall have been gained for the purpose of aiding in treatment.[5]

The communication is privileged if it is made in the presence of a third person who is aiding the physician or who is necessary as a means of communication between physician and patient.[6] But, if the communication is made in the presence of a third person, who is not assisting the physician and who is not necessary as a means of communication between physician and patient, it is not privileged.[7] It has been held in some states that, in such a situation, only the third person, but not the doctor, could testify as to the communications,[8] while in other states it has been held that both the doctor and the third person can testify as to the communications.[9] If the communication is made in the presence of a third person whose character is such that the communication is non-privileged, the patient cannot be compelled to testify as to the communication.[10]

The privilege belongs not to the physician but to the patient, who may waive it. The patient's bringing of a professional liability action against the physician may constitute a waiver of the privilege.[11] The privilege may also be waived if the patient testifies as to the communications[12] or if he calls the physician as a witness.[13]

Fundamentally, the physician-patient privilege, which exists in many jurisdictions in various forms, is a limited right of exclusion of evidence in a judicial or administrative proceeding. Ordinarily, it does not present any issue of legal right of recovery for violation of the privilege. In seeking to recover against a physician for the alleged improper disclosure of information, it appears that the patient's basis for recovery, if any, would depend upon his ability to establish a breach of his right of privacy. This is an area of law which is still in the process of development.

Wisconsin has two statutes relating to communications between a patient and his physician. Section 325.21, Wisconsin Statutes, 1955, establishes a privilege, which is that of the patient and not of the physician. It provides:

"325.21 **Communications to doctors.** No physician or surgeon shall be permitted to disclose any information he may have acquired in attending any patient in a professional character, necessary to enable him professionally to serve such patient, except only (1) in trials for homicide when the disclosure relates directly to the fact or immediate circumstances of the homicide, (2) in all lunacy inquiries, (3) in actions, civil or criminal, against the physician for malpractice, (4) with the express consent of the patient, or in case of his death or disability, of his personal representative or other person authorized to sue for personal injury or of the beneficiary of an insurance policy on his life health, or physical condition."

There is also a penal provision of the Wisconsin Statutes which is probably not well enough known to the physicians or the general public. Section 147.20 (1) (d) includes among the grounds for revocation of a physician's license, the wilfull betrayal of a professional secret. The possibility that wilfullness may be difficult to establish before a court should in no way reduce constant compliance of the physician with this severe provision.

FOOTNOTES

1. Simonsen v. Swenson, 177 N.W. 831 (Neb., 1920).

2. The physician-patient privilege is recgonized in the following jurisdictions: Arizona, Arkansas, California, Colorado, District of Columbia, Idaho, Indiana, Iowa, Kansas, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, New York, North Dakota, Ohio, Oklahoma, Oregon, South Dakota, Utah, Washington, Wisconsin and Wyoming. In Louisiana the privilege applies only in criminal cases. The privilege is recognized in North Carolina but the statute further provides that the presiding judge of a superior court may compel a physician to disclose what he learned while acting in his professional capacity if in his opinion such disclosure is necessary to a proper administration of justice. In Pennsylvania the privilege extends only to information which tends to blacken the character of the patient. The privilege is available, in West Virginia, in the Justice Court only.

3. Toole v. Franklin Investment Company, 291 Pac. 1101 (Wash., 1930); Metropolitan Life Insurance Company v. McSwain, 115 So. 555 (Miss., 1928).

4. Hanlon v. Woodhouse, 160 P. (2d) 998 (Colo., 1945); McMillen v. Industrial Commission of Ohio, 37 N.E. (2d) 632 (Ohio, 1941); Bouligny v. Metropolitan Life Insurance Company, 133 S.W. (2d) 1094 (Mo., 1939); Metropolitan Life Insurance Company v. Evans, 184 So. 426 (Miss., 1938); City of Cherokee v. Aetna Life Insurance Company, 247 N.W. 495 (Iowa, 1933); Moutzoukos v. Mutual Health & Benefit Association, 254 Pac. 1005 (Utah, 1927); Cherpeski v. Great Northern Railway Company, 150 N.W. 1091 (Minn., 1915); Arnold v. City of Maryville, 85 S.W. 107 (Mo., 1905). Contra: Kramer v. Policy Holders' Life Insurance Association, 42 P. (2d) 665 (Cal., 1935); Webb v. Francis J. Lewald Coal Company, 4 P. (2d) 532 (Cal., 1931).

5. In Bassil v. Ford Motor Company, 270 N.W. 258 (Mich., 1936), the patient was examined to determine the cause of his sterility with the hope that it might be possible to remedy the condition. The examination revealed that no treatment would be any help in remedying the condition and none was given. The information acquired in the course of the examination was held privileged. See also: Ballard v. Yellow Cab Company, 145 P. (2d) 1019 (Wash., 1944).

6. Mullin-Johnson Company v. Penn Mutual Life Insurance Company, 2 F. Supp. 203 (N.D. Cal., 1933); North American Union v. Oleske, 116 N.E. 68 (Ind., 1917).

7. Ryan v. Industrial Commission of Ohio, 72 N.E. (2d) 907 (Ohio, 1946); Iwerks v. People, 120 P. (2d) 961 (Colo., 1941); Leeds v. Prudential Insurance Company of America, 258 N.W. 673 (Neb., 1935); Horowitz v. Sacks, 265 Pac. 281 (Cal., 1928); Walmer-Roberts v. Hennessey, 181 N.W. 798 (Iowa, 1921); In re Swartz's Will, 192 Pac. 203 (Okla., 1920); Cincinnati, Hamilton & Dayton Railroad Company v. Gross, 114 N.E. 962 (Ind., 1917); Denaro v. Prudential Insurance Company of America, 139 N.Y. Supp. 758 (1913); Indiana Union Traction Company v. Thomas, 88 N.E. 356 (Ind., 1909); Masons' Union Life Insurance Association v. Brockman, 59 N.E. 401 (Ind., 1901); Springer v. Byram, 36 N.E. 361 (Ind., 1894).

8. Walmer-Roberts v. Hennessey, 181 N.W. 798 (Iowa, 1921); Cincinnati, Hamilton & Dayton Railroad Company v. Gross, 114 N.E. 962 (Ind., 1917); Denaro v. Prudential Insurance Company of America, 139 N.Y. Supp. 758 (1913); Indiana Union Traction Company v. Thomas, 88 N.E. 356 (Ind., 1909); Springer v. Byram, 36 N.E. 361 (Ind., 1894).

9. Horowitz v. Sacks, 265 Pac. 281 (Cal., 1928); in re Swartz's Will, 192 Pac, 203 (Okla., 1920).

10. Indiana Union Traction Company v. Thomas, 88 N.E. 356 (Ind., 1909).

11. Terier v. Davis, 131 N.Y. Supp. 51 (1911).

12. Moutzoukos v. Mutual Benefit Health & Accident Association, 254 Pac. 1005 (Utah, 1927); Blish v. Greer, 120 N.E. 606 (Ind., 1918); Roeser v. Pease, 131 Pac. 534 (Okla., 1913); Epstein v. Pennsylvania Railroad Company, 156 S.W. 699 (Mo., 1913).

13. Whitmore v. Herrick, 218 N.W. 334 (Iowa, 1928); Albers v. Wilson, 195 N.Y. Supp. 145 (1922); Epstein v. Pennsylvania Railroad Company, 156 S.W. 699 (Mo., 1913).

PLACEMENT SERVICE AIDS DOCTORS AND COMMUNITIES

Do you want an associate? Generalist or specialist? Do you need a locum tenens? Then call ALpine 6–3101 or write Box 1109, Madison 1, Wisconsin.

The placement service of the State Medical Society has helped many physicians find a new assistant, found promising locations for young practitioners, and brought resident medical service to many communities without a doctor.

Here is how the placement service may be able to help you. The Society maintains a continuous listing of names and biographical data on physicians who wish to locate in Wisconsin. Usually there are 30 to 50 generalists listed and a total of 80 to 125 specialists in all categories. The Society also maintains a list of physicians and communities offering opportunities to the physician in locum tenens, individual, group, and other types of practice. *The Wisconsin Medical Journal* offers to carry up to one inch of advertising copy for two months without charge when the advertisement is placed by an individual member of the Society. Reasonable rates apply to advertisements by clinics and others.

Physicians who have used the placement service have described it as one of the most effective in the United States. Journal advertising, too, has proved highly successful.

One word of advice: Advise the Society of your needs as soon as possible. Overnight results have occurred, but more time usually means better results.

Form 25.

AUTHORIZATION FOR DISCLOSURE OF INFORMATION BY EXAMINING PHYSICIAN

I authorize Dr._____ to disclose complete information to _____ concerning the results of a physical examination of the undersigned made or to be made on _____ 19__, and to testify, without limitation, as to all findings of said physical examination, in any legal action or judicial proceedings to which I am, or may become a party; and I waive on behalf of myself and any persons who may have an interest in the matter, all provisions of law relating to the disclosure of information acquired through said examination.

Signed_____

Place_____

Witness _____ Date_____

Form 26.

CONSENT TO EXAMINATION OF PHYSICIAN'S RECORDS

To Dr. _____:

I hereby authorize and request you to furnish a copy of the medical records of _____

_____, covering the period from _____ 19____ to
(State name of patient or "myself")

_____ 19____ or to allow those records to be inspected or copied by_____

_____. I hereby release you from all legal responsibility or liability that may arise from the act I have authorized above.

Signed_____

Witness _____ Date_____

Form 27.

AUTHORIZATION FOR DISCLOSURE OF INFORMATION BY PATIENT'S PHYSICIAN

1. I authorize Dr._____ to disclose complete information to _____ concerning his medical findings and treatment of the undersigned from on or about _____ 19___ until date of the conclusion of such treatment.

2. Further, I authorize him to testify, without limitation, as to all of his medical findings and the treatment administered to the undersigned, in any legal action, suit, or proceedings to which I am, or may become a party; and I waive on behalf of myself and any persons who may have an interest in the matter, all provisions of law relating to the disclosure of confidential medical information.

Signed _____

Place _____

Date _____

Witness _____

Form 28.

CONSENT TO ACCESS TO HOSPITAL RECORDS

To _____, Hospital Superintendent, _____Hospital.

I hereby authorize you to furnish a copy of the hospital records of _____ _____, covering the period from _____ 19___ to
(State name of patient or "myself")

_____ 19___ or to allow those records to be inspected or copied by _____ _____. I hereby release _____Hospital and you personally from all legal responsibility or liability that may arise from the act I have authorized above.

Signed _____

Date _____

Witness _____

Form 29.

ORDER FOR TAKING OF X-RAY FILMS

Date_____

Place_____

1. I hereby order the taking of X-ray exposures and films of parts of the person of

_____ as follows: _____.

2. I agree, in part consideration of Dr._____'s undertaking to render professional service to the person named above, that all such X-ray exposures taken and films made by Dr._____, or by any other person at his request, whether or not paid for by the undersigned, shall become a part of Dr._____'s professional records and shall be subject solely to his control and disposition.

3. In addition to the foregoing, I agree to pay charges in the amount of $_____ for services rendered pursuant to this order.

Signed_____

Witness_____

Note. In signing this order for the taking of X-ray films, the patient or the person acting in his behalf acknowledges that such films are to be the property of the physician. It is important for a physician to retain X-ray films as a safeguard in the event of a professional liability suit by the patient so that he may defend his treatment.of the patient. It has been held that, in the absence of an agreement to the contrary, X-rays are the property of the physician rather than the patient, even though the cost of the X-rays was paid by the patient. McGarry v. J. A. Mercier Company, 262 N.W. 296 (Mich., 1935). See also: Reeves v. Pennsylvania Railroad Company, 80 F. Supp. 107 (D.C. Del., 1948). The court compared the case with those involving the negative of an ordinary photograph in which it has been held that the negative belongs to the photographer. Corliss v. E. W. Walker Company, 64 Fed. 280 (C.C. Mass., 1894); Pollard v. the Photographic Company, 60 L.T. 418 (1889). Although the photographer has the right to the negative he may not use it in any way which would violate the subject's rights. However, the physician may, without the express consent of the patient, use X-ray films as evidence in defending a professional liability case.

CHAPTER IV

ARTIFICIAL INSEMINATION

If recent literature is to be believed, physicians are more and more being asked to perform, and are performing, artificial insemination procedures. Artificial insemination may be performed using the semen of the woman's husband or the semen of a donor who is, or should be, unknown to both the woman and her husband and who, conversely, should not know either of them. If the semen of the woman's husband is used the procedure is known as AIH (artificial insemination homologous); if the semen of some other man is used it is known as AID (artificial insemination donor). In all probability, AIH poses few, if any legal problems inasmuch as the child is actually their biological offspring.

In a 1954 Illinois case, the trial court in a declaratory judgment proceeding said that AIH "is not contrary to public policy and good morals, and does not present any difficulty from the legal point of view." But of AID, the Illinois supreme court said, "Heterologous Artificial Insemination. . . . with or without the consent of husband, is contrary to public policy and good morals, and constitutes adultery on the part of the mother. A child so conceived is not a child born in wedlock and therefore illegitimate. As such it is the child of the mother and the father has no right or interest in said child. In a similar New York case, a child resulting from AID which had been performed with the consent of the husband was held not to be illegitimate and the husband was given the right of visitation. It was stated as dictum, in a Canadian divorce case that artificial insemination, without the consent of the husband, is adultery on the part of the wife.

The problems of legitimacy, inheritance, etc. primarily concern the parents and the offspring rather than the physician who performs the artificial insemination. The performance of artificial insemination does, however, create hazards for the physician which necessitate an adequate agreement between him and his patient. As is the case with other medical procedures, the physician cannot free himself from the obligation to use due care and skill in the performance of the procedure itself. The agreement with the parties should cover the points set forth below. (1) The wife should consent in writing to the procedure because otherwise its accomplishment would constitute an assault and battery. (2) The written consent of the husband should be obtained because the procedure seriously affects and involves the marital relationship. (3) The donor should consent in writing to the unrestricted use of the semen he supplies and should certify that he will make no effort to ascertain the identity of the husband and wife involved. (4) Although the possibility of suit by her is remote, the written consent of the donor's wife to the giving of the semen may also be desirable inasmuch as her marital interests are affected. (5) The physician should have permission to use his own best judgment in selecting the outside donor. The law has not as yet delineated the responsibilities of the physician on this score, but it would seem that he would be obligated to use reasonable care in selecting a healthy donor who has no knowable transmissible disease.

It cannot be too strongly emphasized that obtaining the consent and observing the precautions mentioned above may cover at most only the physician's civil responsibilities. No court decisions and no statutes have as yet spelled out any criminal aspects of artificial insemination. If the procedure should be held to be a criminal offense, in all probability it would be the physician, rather than the donor, who would be regarded as the guilty party. The donor has no control over the use of the semen; it is the physician who, by his own voluntary act, has actually interfered with the wife's reproductive faculties and caused the birth of any

child that may result. If the performance of artificial insemination should be held to be a criminal offense, the fact that the patient consented may not be a defense to the physician. It has generally been held that consent to perform a criminal act is a nullity.

Inasmuch as neither the legislature nor the supreme court of Wisconsin have yet indicated what the civil or criminal position of the physician may be with respect to his part in the performance of artificial insemination, it cannot be said with any certainty that any degree of caution on his part, or any agreement he may have with a wife, husband or donor of semen, will protect him from possible civil or criminal liability. A physician who is requested to perform professional services in such a case will be well advised to consult with his personal attorney before proceeding.

U. S. TREASURY MAY PERMIT DEDUCTIBLE MEDICAL PENSION PLANS

Several years ago, a partnership of physicians known as the Western Montana Clinic so rearranged its organizational structure that it formed what is known in law as an "association." Such an organization looks and operates much like a corporation, although in fact it has not been formally incorporated. Under a Federal income tax law, if an association has more of the marks of a corporation than of a partnership, it may be taxed as if it were a corporation, and its partner members may be paid salaries and otherwise treated for tax purposes as if they were employees.

A major tax advantage of having a partnership of physicians reorganize as an association is that it permits the establishment of a tax-deferred pension plan in which the partner members may participate. This is not permitted under a conventional partnership, since partners are not employees. The annual cost of such a pension plan is deductible out of association income within permitted limits.

The tax status of this particular association of physicians was challenged by the Treasury. The arrangement was upheld first by a Federal district court in Montana, and in 1954 by the Federal Circuit Court of Appeals in San Francisco. The essence of the holding was that the Western Montana Clinic was more like a corporation than a partnership. The Federal Government, in recognition of this fact, permitted the clinic to be treated for Federal income tax purposes as a corporation. It was also held that the pension plan established by the association met the requirements of the Internal Revenue Code permitting the establishing of tax-deferred pension plans for employees. Further, years of service as medical partners constituted qualifying years of employment for purposes of the pension plan of the association.

Shortly after the court's decision, the Treasury announced that it would continue to oppose and litigate against this type of organization in other areas of the United States, including Wisconsin. The result has been that any Wisconsin group which attempted to duplicate the association organization of the Western Montana Clinic was virtually certain to be challenged by the Federal tax authorities.

Recently the U. S. Treasury has announced that it planned to issue new regulations setting out certain requirements which, if met, would recognize for tax purposes the "Kintner type" of professional association, as it has come to be called. Such recognition would include the approval and deductibility of pension plans for its professional and other employees, including those who are actually partners.

If and when the Treasury issues such regulations, it should be possible for a medical partnership in Wisconsin to form such an association in compliance with the conditions imposed by those regulations. By so doing, substantial tax advantages will accrue to medical partners analogous to those which might be permitted by the Jenkins-Keogh bills. A qualifying association can deduct the annual cost of a pension plan from gross professional income as an expense. No medical partner will have to pay an income tax on his share of the pension fund until he receives benefits from it.

It is emphasized that any such arrangement will require careful planning and study on the part of interested physician partners, and their financial, accounting, and legal advisors. Neither tax-exempt status nor approval of such a program will be automatic.

Chapter V

THE PHYSICIAN-PATIENT RELATIONSHIP

A physician is not required to accept as patients all who apply to him for treatment. He may arbitrarily refuse to accept any person as a patient, even though no other physician is available.[1] The physician-patient relationship begins when the physician, in response to an express or implied request that he treat the patient, undertakes to render services. The mere rendering of such services as may be necessary in an emergency does not give rise to the relation,[2] but the physician is required to use due skill and care in administering emergency treatment.

After the physician-patient relation has been entered into, the physician is under an obligation, in absence of a special agreement, to attend the case as long as it requires attention, unless he gives notice of his intention to withdraw from the case or is dismissed by the patient.[3] A physician cannot withdraw from a case and relieve himself from liability with respect thereto by simply staying away without notifying the patient of his withdrawal.[4] If the physician wishes to withdraw from a case, he must give the patient reasonable notice of his withdrawal in order that the patient may secure other medical attention if he desires.[5] What is reasonable notice to the patient depends upon the circumstances of each case.[6] Factors to be taken into consideration are the condition of the patient, the size of the community and the availability of other physicians.[7]

If the physician wishes to withdraw from a case, he should make this desire clear to the patient. To provide himself with the greatest degree of protection with respect to the matter, the physician should write a letter to the patient explaining the situation. This letter should preferably be sent by registered mail and the return receipt, together with a copy of the letter, should be retained in the physician's file. If the physician is discharged from a case by the patient who is in need of further medical attention or if the patient leaves the hospital against the physician's advice, the physician should be in a position to establish that he did not abandon the case, but was discharged by the patient, or that the patient acted contrary to his advice.[8] He may protect himself in this matter by obtaining a signed statement of the facts from the patient or by sending a letter to the patient confirming the discharge or the fact that the patient left the hospital against the advice of the physician. Again the letter should preferably be sent by registered mail and the return receipt, together with a copy of the letter should be retained in the physician's files.

The physician may, by special agreement with the patient, limit his engagement to treat the patient to one particular treatment or procedure or to administering treatment at a particular time or place.[9]

If a physician, who has entered into a general agreement of treatment, is unable to treat the patient when his services are needed, he may provide a substitute to render the services.[10] However, the substitute that is sent must be qualified and competent.[11] Although it has been held that a physician may send a substitute when the case is an obstetrical one,[12] because of the more personal nature of the physician-patient relationship in such cases, the physician should, if possible, obtain the written consent of the patient to a substitution in the event that he may be unable to come when needed.

FOOTNOTES

1. Limbaugh v. Watson, 12 O.L. Abs. 150 (Ohio, 1932); Hurley v. Eddingfield, 59 N.E. 1058 (Ind., 1901).

2. Birmingham Baptist Hospital v. Crews, 157 So. 224 (Ala., 1934).

3. Nelson v. Farrish, 173 N.W. 715 (Minn., 1919); Lawson v. Conaway, 16 S.E. 564 (W.Va., 1892).

4. Bolles v. Kinton, 263 Pac. 26 (Colo., 1928).

5. Norton v. Hamilton, 89 S.E. (2d) 809 (Ga., 1955); Sibert v. Boger, 260 S.W. (2d) 569 (Mo., 1953); McGulpin v. Bessmer, 43 N.W. (2d) 121 (Iowa, 1950); Groce v. Myers, 29 S.E. (2d) 553 (N.C., 1944); Gray v. Davidson, 130 P. (2d) 341 (Wash., 1942); Baird v. National Health Foundation, 144 S.W. (2d) 850 (Mo., 1940); Ricks v. Budge, 64 P. (2d) 208 (Utah, 1927); Fortner v. Koch, 261 N.W. 762 (Mich., 1935); Burnett v. Layman, 181 S.W. 157 (Tenn., 1915); Ballou v. Prescott, 64 Me. 305 (1872).

6. Burnett v. Layman, 181 S.W. 157 (Tenn., 1915).

7. In Sibert v. Boger, 260 S.W. (2d) 569 (Mo., 1953), it was held that the physician did not abandon the case when he directed the patient to go to somebody else because she was consulting another physician at the time and the city was sufficiently large that medical services could have been obtained any day. See also: Urrutia v. Patino, 297 S.W. 512 (Tex., 1912).

8. Pearson v. Norman, 106 P. (2d) 361 (Colo., 1940); Muckleroy v. McHenry, 16 P. (2d) 123 (Okla., 1932); Duke Sanitarium v. Hearn, 13 P. (2d) 183 (Okla., 1932).

9. McNamara v. Emmons, 97 P. (2d) 503 (Cal., 1939); Dabney v. Briggs, 121 So. 394 (Ala., 1929); Nelson v. Farrish, 173 N.W. 715 (Minn., 1919); Urrutia v. Patino, 297 S.W. 512 (Tex., 1912).

10. Jackowicz v. Knobloch, 265 N.W. 799 (Mich., 1936); Jackson v. Burton, 147 So. 414 (Ala., 1933); Stohlman v. Davis, 220 N.W. 247 (Neb., 1928); Young v. Jordan, 145 S.E. 41 (W. Va., 1928).

11. Stohlman v. Davis, 220 N.W. 247 (Neb., 1928).

12. Jackowicz v. Knobloch, 265 N.W. 799 (Mich., 1936); Young v. Jordan, 145 S.E. 41 (W. Va., 1928). Contra: Hood v. Moffett, 69 So. 664 (Miss., 1915).

DO YOU EMPLOY FOUR OR MORE PERSONS?

If you do, then you must pay unemployment insurance taxes.

Employers, including physicians, who employ four or more persons for some portion of the day on at least one day in each of 20 weeks in a calendar year are subject to both the state and federal unemployment insurance tax.

The combined state and federal tax is 3% of the first $3,000 of annual wages paid to all employees, of which 2.7% is payable to the state and 0.3% to the federal government.

The report and payment to the federal government is due by January 31 of the subsequent calendar year. Reports and payments to the state are due quarterly during the year in the months of April, July, October, and January. The exact date within the month is set by the state. These reports and payments are due regardless of whether the employer has been notified by either of the governments or has received tax forms.

If a physician or clinic has employed four or more persons in any portion of each of 20 weeks during the current year and has failed to pay the quarterly payments to the state, this should be done promptly so as to keep at a minimum any penalties and interest which will be due. Payment of the federal unemployment insurance tax should be made by January 31.

Form 33.

PROVISION FOR SUBSTITUTE PHYSICIAN AT DELIVERY

Date _____

Place _____

To Dr. _____ :

In engaging you as my obstetrician, I understand that if you are unavailable or unable for any reason to be present and to deliver me, at the time of my confinement, you will make a reasonable effort to refer me to another duly licensed physician to render obstetrical care. I agree to hold you free from any duty, liability or responsibility in connection with any services that may be performed by any physician to whom you refer me or whom I may call.

Signed _____

Witness _____

Note. If the husband is present at the time that the arrangements are made, it is desirable that he should witness his wife's execution of this form.

Form 34.

LETTER TO PATIENT WHO FAILS TO KEEP APPOINTMENT

Dear Mr. _____:

On _____ 19____, you failed to keep your appointment at my office. In my opinion your condition requires continued medical treatment. If you so desire, you may telephone me for another appointment, but if you prefer to have another physician attend you, I suggest that you arrange to do so without delay. You may be assured that, at your request, I am entirely willing to make available my knowledge of your case.

I trust that you will understand that my purpose in writing this letter is out of concern for your health and well-being.

Very truly yours,

_____, M.D.,

Form 35.

LETTER TO PATIENT WHO FAILS TO FOLLOW ADVICE

Dear Mr. _____:

At the time that you brought your son, William, to me for examination this afternoon, I informed you that I was unable to determine without X-ray pictures whether a fracture existed in his injured right arm. Although I insisted and still do insist that an X-ray study should be made of William's arm, you have refused to follow my advice. I strongly urge you to permit me or some other physician of your choice to make this X-ray examination without further delay.

Your neglect in not permitting a proper X-ray examination to be made of William's arm may result in serious consequences if in fact a fracture does exist.

Very truly yours,

_____, M.D.

Form 36.

LETTER TO CONFIRM DISCHARGE BY PATIENT

Dear Mr._____:

This will confirm our telephone conversation of today in which you discharged me from attending you as your physician in your present illness. In my opinion your condition requires continued medical treatment by a physician. If you have not already done so, I suggest that you employ another physician without delay. You may be assured that, at your request, I will furnish him with complete information regarding all medical facts, diagnosis, and treatment which you have received from me.

Very truly yours,

_____, M.D.

Form 37.

LETTER OF WITHDRAWAL FROM CASE

Dear Mr._____:

I find it necessary to inform you that I am withdrawing from further professional attendance upon you for the reason that you have persisted in refusing to follow my medical advice and treatment. Since your condition requires medical attention, I suggest that you place yourself under the care of another physician without delay. If you so desire, I shall be available professionally to attend you for a reasonable time after you have received this letter, either for regular or emergency medical treatment, but in no event for more than five days following such receipt. This should give you ample time to select a physician of your choice from the many competent practitioners in this city. With your approval, I will make available to this physician your case history and complete information regarding the diagnosis and treatment which you have received from me.

Very truly yours,

_____, M.D.

Form 38.

STATEMENT OF PATIENT LEAVING HOSPITAL AGAINST ADVICE

This is to certify that I am leaving _____Hospital at my own insistence and against the advice of the hospital authorities and my attending physician. I have been informed by them of the dangers attendant on my leaving the hospital at this time. I assume all responsibility for any results caused by leaving the hospital prematurely, and I hereby release the hospital, its employees and officers, and my attending physician from all liability of whatsoever nature in the premises.

Signed _____

I hereby agree to hold harmless the _____Hospital, its employees and officers, and my attending physician, from all liability of whatsoever nature, with reference to the discharge of the patient named above.

_____
(Husband, wife, parent, etc.)

Date _____

Witness _____

Note. If the patient refuses to sign such a statement, he cannot be forced to do so, legally, nor may his release be withheld until he signs. If this occurs, the form should be filled out, witnessed by the hospital personnel present, and the statement made on the form "signature refused."

Chapter VI

AUTOPSY

After the death of a patient, his right to freedom from interference automatically passes in a modified form to his spouse or to his next of kin, and any unauthorized interference with his dead body exposes the offender to a suit for damages by the person entitled to its custody.[1] One who participates in an autopsy to which the surviving spouse or next of kin has not consented and which is not authorized by law is also subject to criminal prosecution.[2]

Generally, the person entitled to posession of a body for purposes of burial is entitled to authorize an autopsy upon it to determine the cause of death. The right to the body, and the attendant right to give or withhold consent to an autopsy, does not vest in the executor.[3] The right vests in the surviving spouse, providing he or she was living with the deceased at the time of death in the normal relations of marriage.[4] If the surviving spouse is not living with the deceased at the time of death in the normal relations of marriage,[5] or if the surviving spouse waives the right,[6] it will vest in the next of kin. So long as the surviving spouse asserts her rights to the body and does not abuse it, the next of kin have no rights with respect to the body and have no cause of action for the performance of an unauthorized autopsy on it.[7] If there is no surviving spouse, the right vests in the next of kin, in order of kinship.[8] Under such circumstances, a child of the deceased has rights superior to those of anyone else, unless it be the coroner or medical examiner.[9] If the deceased is not survived by a child or children, authority over the dead body normally vests in the parents.[10] It is not clear in those cases where the deceased child is a minor whether the consent of the father only is sufficient or whether the consent of the mother is also necessary.[11] If the parents of the deceased minor child are divorced or separated, consent to the autopsy should be obtained from the parent who has custody of the child.[12] In the absence of a child, children or parents, authority over the dead body normally vests in brothers and sisters and so on through various degrees of consanguinity.

There are statutes in some states which provide for the order of the right to control of a dead body.[13] The law has not undertaken to fix the relative rights of persons of equal degree of kinship, that is, the relative rights of several children, or of several brothers and sisters, and so on. Generally, it will be found that some one of a given group of children or brothers and sisters will be at the place of death and will assume charge of the body and it is to such a one that application should be made for permission to perform an autopsy.

The Wisconsin Statutes covering autopsies reads as follows:

"155.05 **Post mortem examinations.** Consent for a licensed physician to conduct a post mortem examination of the body of a deceased person shall be deemed sufficient when given by whichever one of the following assumes custody of the body for purposes of burial: Father, mother, husband, wife, child, guardian, next of kin, or in the absence of any of the foregoing, a friend, or a person charged by law with the responsibility for burial. If 2 or more such persons assume custody of the body, the consent of one of them shall be deemed sufficient."

A Kentucky court has held that a physician is not liable where, without the consent of the relatives of the deceased, he performs an autopsy to determine the cause of death in order to comply with a statute which requires the physician's certification as to the cause of death.[15] However, this does not appear to be the general rule.

The deceased may have left directions that an autopsy should be performed on his body. The trend of the American cases is to honor the deceased's directions as to the disposition of his body.[16] There are statutes in a number of states providing that a person may, in his lifetime, direct

what is to be done with his body after death.[17] With the exception of the California statute, these provide that the authorization must be in writing; under the California statute, the direction must be in writing only if it directs that the remains are to be given to a teaching institution or hospital. In some states the workmen's compensation commission is permitted to order an autopsy when it is claimed that death resulted from an occupational cause. Sometimes an insurance policy will permit an autopsy and in states recognizing such consents, the physician acting under such authority will be protected.[18]

Authority of Coroner

In all jurisdictions, a public official, known either as the coroner or medical examiner, has legal authority to perform autopsies with respect to deaths due to other than natural causes. When death is due to violence or casualty or there is reasonable ground for believing that it has been caused in that way, the right to custody of a dead body vests immediately in the coroner or the medical examiner. When the coroner or medical examiner has legal control of a dead body his authority is supreme. He is entitled to the body in the condition in which it was at the moment of death. In general, he is authorized to perform or procure an autopsy in any body coming into his lawful custody.[19]

It is, therefore, important that a physician should not undertake to perform an autopsy without the consent of the coroner or medical examiner in any case in which the body is properly within jurisdiction of such officer, even though the surviving spouse or next of kin may have consented. If the coroner or medical examiner authorizes the performance of an autopsy on a body which is not within his jurisdiction, he and those who perform the autopsy at his direction are liable to the surviving spouse or next of kin.[20] Therefore, it is equally important for the physician that he undertake to perform no autopsy on the basis of authority from the coroner or medical examiner unless he is sure that the officer has jurisdiction over the body and power to authorize the autopsy. Where the jurisdiction of the coroner or medical examiner is doubtful, consent should also be obtained from the surviving spouse or next of kin.

Limitations on Autopsy

All autopsies must be performed in a manner which shows decent respect for the body.[21] In the absence of a specific restriction, consent to an autopsy by implication authorizes the physician to conduct it in the usual and approved manner practiced by the profession and to remove for examination and study such parts as must be examined and studied in order to accomplish the purpose of the autopsy.[22] However, authority to remove parts or organs for study and examination does not, in the absence of a specific agreement, include the authority to retain them permanently.[23] If there is no specific authorization for retention of organs or parts of the body, those that have been removed must be replaced in the body cavity before interment. The person who has the right to authorize an autopsy has the right to state the limits within which it shall be performed, and the autopsy must be performed strictly within those limits.[24]

Form of Consent

A number of states have statutes which provide that consent to an autopsy must be in writing.[25] Although a nonwritten consent may be legally sufficient in some states, a physician should not perform an autopsy without having first obtained a specific written consent or authorization which he can produce as proof in the event of a subsequent challenge to his authority. As with consents to surgical operations, the consent to autopsy should be specific rather than general. If it is necessary or desirable to remove and retain parts of the body for further study and examination, even though they be but minute sections for microscopic study, specific consent should be obtained. Although it has been held that a physician may lawfully perform an autopsy under consent obtained in his behalf by some other person,[26] the physician may best protect himself by personally obtaining the consent from those authorized to give it.

FOOTNOTES

1. Trammell v. City of New York, 82 N.Y.S. (2d) 762 (1948); Steagall v. Doctors Hospital, 171 F. (2d) 352 (D.C. Cir., 1948); Beller v. City of New York, 58 N.Y.S. (2d) 112 (1945); Simpkins v. Lumbermens Mutual Casualty Company, 20 S.E. (2d) 733 (S.C., 1942); Alderman v. Ford, 72 P. (2d) 981 (Kan., 1937); McPosey v. Sisters of the Sorrowful Mother, 57 P. (2d) 617 (Okla., 1936); Aetna Life Insurance Company v. Lindsay, 69 F. (2d) 627 (7th Cir., 1934); Darcy v. Presbyterian Hospital in City of New York, 95 N.E. 695 (N.Y., 1911); Louisville & Nashville Railroad Company v. Blackmon, 59 S.E. 341 (Ga., 1907); Medical College of Georgia v. Rushing, 57 S.E. 1083 (Ga., 1907); Koerber v. Patek, 102 N.W. 40 (Wis., 1905); Burney v. Children's Hospital in Boston, 47 N.E. 401 (Mass., 1897); Foley v. Phelps, 37 N.Y. Supp. 471 (1896); Larson v. Chase, 50 N.W. 238 (Minn., 1891).

2. All of the states have statutes making criminal any unauthorized disturbance of or interference with a dead body.

3. Burney v. Children's Hospital in Boston, 47 N.E. 401 (Mass., 1897).

4. Foley v. Phelps, 37 N.Y. Supp. 471 (1896); Larson v. Chase, 50 N.W. 238 (Minn., 1891).

5. Morrow v. Cline, 190 S.E. 207 (N.C., 1937).

6. Southern Life & Health Insurance Company v. Morgan, 105 So. 161 (Ala., 1925).

7. Trammell v. City of New York, 82 N.Y.S. (2d) 762 (1948); Steagall v. Doctors Hospital, 171 F. (2d) 352 (D.C. Cir., 1948); Aetna Life Insurance Company v. Lindsay, 69 F. (2d) 627 (7th Cir., 1934).

8. Beller v. City of New York, 58 N.Y.S. (2d) 112 (1945); O'Donnell v. Slack, 55 Pac. 906 (Cal., 1899).

9. Koerber v. Patek, 102 N.W. 40 (Wis., 1905).

10. Stephenson v. Duke University, 163 S.E. 698 (N.C., 1932); Coty v. Baughman, 210 N.W. 348 (S.D., 1926); Darcy v. Presbyterian Hospital in City of New York, 95 N.E. 695 (N.Y., 1911); Palenzke v. Bruning, 98 Ill. App. 644 (1901).

11. In Stephenson v. Duke University, 163 S.E. 698 (N.C., 1932), it was held that, since the father has the primary duty to support the child, which support would include burial, only he has a cause of action for the performance of an unauthorized autopsy on the child. So long as the father is alive, the mother has no cause of action for the wrongful act. However, in Coty v. Baughman, 210 N.W. 348, 350 (S.D., 1926), the court said· "We think the rights of the father and mother are equal in the body of their deceased child, and that the consent of both to an autopsy would be necessary where the father and mother were living together and both were within this state."

12. Rader v. Davis, 134 N.W. 849 (Iowa, 1912).

13. E.g., s. 7100 of the California Health and Safety Code (Deering, 1952) provides the following order of the right to control: (1) surviving spouse, (2) child or children, (3) parent or parents, (4) those persons in next degree of kinship.

14. Wis. Stat. (1955) s. 155.05.

15. Meyers v. Clarke, 90 S.W. 1049 (Ky., 1906). The court was undoubtedly influenced by the fact that the deceased's next of kin had virtually abandoned the body and left it in the hands of the hospital authorities to dispose of as best they could. Contra: Woods v. Graham, 167 N.W. 113 (Minn., 1918).

16. Beller v. City of New York, 58 N.Y.S. (2d) 112 (1945); Wales v. Wales, 190 Atl. 109 (Del., 1936); Painter v. United States Fidelity & Guaranty Company, 91 Atl. 158 (Md., 1914); Darcy v. Presbyterian Hospital in City of New York, 95 N.E. 695 (N.Y., 1911); O'Donnell v. Slack, 55 Pac.

906 (Cal., 1899); Larson v. Chase, 50 N.W. 238 (Minn., 1891); Pierce v. Proprietors of Swan Point Cemetary, 10 R.I. 227 (1872).

17. Ark. Stat. Ann. (1947) s. 82-408; Cal. Health and Safety Code (Deering, 1952) s. 7100; Iowa Code (1954) s. 141.35; Kan. Gen. Stat. Ann. (1949) s. 19-1025; Minn. Stat. (1953) s. 525.18(2); Mont. Rev. Code (1947) s. 69-2308; N.D. Rev. Code (1943) s. 23.0601; Utah Code Ann. (Supp., 1953) s. 26-15-18; Wash. Rev. Code (1951) s. 68.08.100. The Arkansas statute also provides that a person may, in writing, dispose of a part of his body for the purpose of replacing or rehabilitating the parts or organs of another human.

18. Palmquist v. Standard Accident Insurance Company, 3 F. Supp. 358 (S.D. Cal., 1933).

19. Sturgeon v. Crosby Mortuary, 299 N.W. 378 (Neb., 1941); Kingsley v. Forsyth, 257 N.W. 95 (Minn., 1934); Palenzke v. Bruning, 98 Ill. App. 644 (1901).

20. Gurganious v. Simpson, 197 S.E. 163 (N.C., 1938); Streipe v. Liberty Mutual Insurance Company, 47 S.W. (2d) 1004 (Ky., 1932); Coty v. Baughman, 210 N.W. 348 (S.D., 1926); Darcy v. Presbyterian Hospital in City of New York, 95 N.E. 695 (N.Y., 1911); Hassard v. Lehane, 128 N.Y. Supp. 161 (1911); Palenzke v. Bruning, 98 Ill. App. 644 (1901).

21. Young v. College of Physicians & Surgeons of Baltimore City, 32 Alt. 177 (Md., 1895).

22. Palmquist v. Standard Accident Insurance Company, 3 F. Supp. 358 (S.D. Cal., 1933); Winkler v. Hawkes & Ackley, 102 N.W. 418 (Iowa, 1905).

23. Palmquist v. Standard Accident Insurance Company, 3 F. Supp. 358 (S.D. Cal., 1933); Hassard v. Lehane, 128 N.Y. Supp. 161 (1911); Winkler v. Hawkes & Ackley, 102 N.W. 418 (Iowa, 1905); Palenzke v. Bruning, 98 Ill. App. 644 (1901).

24. Hill v. Travelers' Insurance Company, 294 S.W. 1097 (Tenn., 1927); Koerber v. Patek, 102 N.W. 40 (Iowa, 1905); Winkler v. Hawkes & Ackley, 102 N.W. 418 (Wis., 1905).

25. Cal. Health and Safety Code (Deering, Supp. 1955) s. 7113; Conn. Gen. Stat. (1949) s. 4219; Iowa Code (1954) s. 141.35; Kan. Gen. Stat. Ann. (1949) s. 19-1025; Mich. Stat. Ann. (Supp. 1953) s. 14.524; Mont. Rev. Code (1947) s. 69-2308, See: Division of Labor Enforcement v. Gifford, 290 P. (2d) 281 (Cal., 1955).

26. Division of Labor Enforcement v. Gifford, 290 P. (2d) 281 (Cal., 1955).

Form 39.

AUTHORIZATION FOR AUTOPSY

NAME OF DECEASED _____ AGE _____ SEX _____

RACE _____ MARITAL STATUS _____ DATE OF DEATH _____

1. I hereby authorize Dr. _____, and such persons as he may designate, to perform and attend a complete autopsy on the remains of _____ _____ for the purpose of determining the cause of death. Authority is also granted for the preservation and study of any and all tissues or parts which may be removed. This authority shall be limited only by the following express conditions:

(e.g. "limited to abdomen," etc.) _____

_____

2. It is understood that due care will be taken to avoid mutilation or disfigurement of the body.

3. This authorization is given with the understanding that no charge will be made and that I will be informed of the results of this autopsy.

Signature of next of kin _____

Address _____

City and State _____

Relationship to the deceased _____

Signature of Witness _____

Address _____

City and State _____ Date _____

Note: Next of Kin. For the purpose of this form the surviving spouse shall be considered the next of kin. In the absence of a surviving spouse, the next of kin shall be identified in accordance with the applicable State law.

Form 40.

AUTHORIZATION FOR AUTOPSY AND TISSUE DONATION

1. I hereby request and authorize Dr._____

to perform a complete autopsy on the remains of_____

for the purpose of determining the cause of death. Authority is also granted to remove tissues and parts for preservation and study, or for use in grafts upon living persons, or to otherwise dispose of these tissues and parts in proper and suitable manner. This authority shall be limited only by the conditions expressly stated in paragraph 4 below.

2. It is understood that due care will be taken to avoid unnecessary disfigurement of the body.

3. This authorization is given with the understanding that no expense to the estate of the deceased or the undersigned is incurred there by and that I will be advised of the cause of death of the deceased.

4. Conditions:_____

_____

Signature of
Next of kin _____

Address _____

City and State_____

Relationship to
the deceased _____

Signature of witness _____

Address _____

City and State_____ Date _____

Note. Next of kin: For the purpose of this form the surviving spouse shall be considered the next of kin. In the absence of a surviving spouse, the next of kin shall be identified in accordance with the applicable State Law.

PHYSICIANS EXEMPT FROM JURY DUTY

You don't have to serve as a juror unless you want to. All practicing physicians, surgeons, and dentists are exempt. This doesn't mean that you are disqualified from jury duty. The exemption is a personal privilege which you may claim or waive as you wish.

If you are called to act as a juryman and wish to take advantage of your exemption, appear in court when called and state the cause of your exemption to the presiding judge.

Reference: *Section 255.02 (2), Wisconsin Statutes, 1957.*

Form 41.

AUTHORIZATION FOR TISSUE DONATION

To Dr._____:

1. You are hereby authorized to remove the following tissues:_____

_____

(Insert: bone, artery, cartilage, skin, fascia, dura, nerve, tendon or eyes

_____ from the remains of _____

as desired.)

_____, for donation of the aforementioned tissues to_____

_____. Authority is also granted to use the removed tissues in grafts upon living persons, or to otherwise dispose of these tissues in accordance with customary medical practice.

2. It is understood that due care will be taken to avoid unnecessary disfigurement of the body.

Signature of
next of kin _____

Address _____

Relationship to
the deceased _____

Signature of witness_____ Date _____

Address_____

City and State _____

Note: Next of Kin: For the purpose of this form the surviving spouse shall be considered the next of kin. In the absence of a surviving spouse, the next of kin shall be identified in accordance with the applicable State law.

LIQUOR PRESCRIPTIONS

The friend may be penny wise, but the physician is pound foolish who prescribes for the friend's thirst or do-it-yourself proclivities rather than for his health. The friend will have the pleasure of his potion and perhaps the joy of a tax saving. But the physician will be subject to a fine of from $250 to $1,000 and to imprisonment for up to six months. If convicted twice, his license to practice may be revoked.

Section 176.19 of the Wisconsin Statutes imposes the above penalties for prescribing intoxicating liquors beyond what is necessary for health if done with intent to evade tax or license requirements for the sale of liquor.

Form 42.

CONSENT TO DISPOSAL OF DEAD FETUS

Date _____

We hereby authorize and request _____

to preserve for scientific purposes, or to dispose of, the dead fetus or the body of the baby

born to _____ on _____ , 19____, in accordance with customary medical practice. All claims to the body are hereby relinquished.

Signed _____

Signed _____

Witness _____

Note: This consent should be executed by both parents, except that in the case of an unmarried mother her consent is sufficient.

WHAT ARE YOUR RIGHTS IN EMERGENCIES?

Question: Suppose a physician in private practice serves as advisor to his local police department. The department calls him, either to the police station or to a private home, where a belligerent alcoholic is creating a disturbance. The physician gives a hypodermic injection to calm him, without the alcoholic's consent, and with or without the nearby relatives' consent. The alcoholic is believed to be endangering himself or those in his environment. Is the physician within his legal rights as a doctor called by the police?

Suppose a similar sequence occurs with a mentally ill patient. The police are following the physician's orders in these circumstances. To protect the patient and others from the violence of the patient, the physician orders restraints applied. Is he within his legal rights as a doctor called in by the police? Assume that no relative is immediately available to take responsibility of the patient.

Answer: Generally, a physician has no authority to administer a hypodermic injection or any other treatment to a patient without the consent of the patient or someone authorized to act on his behalf. If the patient is mentally incapable of speaking for himself because of intoxication, injury, illness, or insanity, consent must be obtained from someone legally authorized to act on behalf of the patient.

An exception is permitted in the case of an emergency, where the patient's life is endangered. Under these circumstances, the law will presume the patient's consent on the theory that, if the patient were rational and able to make his own decision, he would consent to treatment.

A physician going into a private home has no authority to treat the patient without the consent of the patient, or someone authorized to act on his behalf, unless a bona-fide emergency exists in which the patient's life is endangered. Except with regard to persons committed to state institutions, and other situations where specific statutory authority is granted, the police have no authority to authorize a physician to drug a patient against his will solely because he is creating a disturbance or endangering others. The police have power to restrain such an individual by force, if necessary, although force does not include the use of drugs. However, where a patient becomes so violent that it is necessary to restrain him with drugs, the situation is usually one where treatment can be justified because of a bona-fide emergency. **Reference:** "The Physician's Legal Rights in Emergencies," J.A.M.A. (Queries and Minor Notes Section) 161:1518 (Aug. 11) 1956.

PHYSICAL EXAMINATION FOR SCHOOL EMPLOYES

PERIODIC physical examination is required of all public, private, or parochial school employes as a condition of entering or continuing employment.

This requirement was enacted by the Wisconsin Legislature in 1957, marking the end of a concerted drive by the State Medical Society for such legislation over a period of several legislative sessions. The law is set forth in Section 40.30 (10m) (a) and Section 143.16 of the Wisconsin Statutes.

The first section relates to physical examinations for employes of public schools and the second applies to employes of private or parochial schools. The specific sections of the Statutes read as follows:

Examinations for Employes of Public Schools

"40.30 (10m) (a) The district board shall, as a condition of entering or continuing employment, except in cities of the first class, require a physical examination including a chest X-ray or tuberculin test, of every school employe of the district. If the reaction to the tuberculin test is positive then a chest X-ray shall be required. Additional physical examinations shall be required thereafter at intervals determined by the board. A chest X-ray or tuberculin test shall be required at least once every 3 years; if the reaction to such tuberculin test is positive then a chest X-ray shall be required. The employe shall be examined by a licensed physician in the employ of or under contract with the district. If no such physician is employed or under contract, the examination shall be made by any licensed physician selected by the employe. Such physical examinations, chest X-rays or tuberculin tests shall not be required of any such employe who files with the board an affidavit setting forth that he depends exclusively upon prayer or spiritual means for healing in accordance with the teachings of a bona fide religious sect, denomination or organization and that he is to the best of his knowledge and belief in good health and that he claims exemption from health examination on such grounds. Notwithstanding the filing of such affidavit if there is reasonable cause to believe that such employe is suffering from an illness detrimental to the health of the pupils, the board may require such health examination of such employe sufficient to indicate whether or not such employe is suffering from such an illness. No employe shall be discriminated against by reason of his filing the aforementioned affidavit. The physician making such examination shall prepare a report of his examination upon a standard form prepared by the state board of health and the department of public instruction. Such report shall be retained in the physician's files and he shall make confidential recommendations therefrom to the board and to the employe on a form prepared by the state board of health and the department of public instruction. The recommendation form shall contain space for a certificate that the person is free from tuberculosis in a communicable form. The cost of such examinations, including X-rays and tuberculin tests, shall be paid out of district funds."

Examinations for Employes of Private or Parochial Schools

"143.16 Physical Exams for Teachers. The governing body of each private or parochial school enrolling pupils in any grades from 1 to 12 shall as a condition of entering or continuing such employment require a physical examination, including a chest X-ray or tuberculin test of every school employe. If the reaction to the tuberculin test is positive then a chest X-ray shall be required. Additional physical examinations shall be required thereafter at intervals determined by the board. A chest X-ray or tuberculin test shall be required at least once every 3 years; if the reaction to such tuberculin test is positive then a chest X-ray shall be required. The physician making such examination shall prepare a report of his examination and make confidential recommendations therefrom to the governing body of the school and to the employe. The recommendation form shall contain space for a certificate that the person is free from tuberculosis in a communicable form."

The law became effective on July 25, 1957, and applies only to school employes hired after that date. However, when employes hired before that date receive new contracts or enter into employment for a subsequent employment period, the physical examination is required as a condition "of continuing employment."

The law applies to all public schools except those in the City of Milwaukee, which have been covered by similar legislation for sev-

TO THE EXAMINING PHYSICIAN: COMPLETE THIS EXAMINATION FORM, AND RETAIN IT IN YOUR FILES AS REQUIRED BY STATUTE

Physician's Record of School Employe Examination

Prepared by the Wisconsin State Board of Health and Wisconsin State Department of Public Instruction as Required by Section 40.30 (10m) (a) of the Statutes.

NAME OF EMPLOYE_____ ADDRESS_____

BIRTH DATE_____ HEIGHT_____ WEIGHT_____ DATE OF PRESENT EXAM_____

PHYSICAL EXAMINATION AND PERTINENT HISTORY: (Mark none if not significant)

Nose and Sinuses
Mouth and Throat
Vision: Without glasses_____ With glasses_____
Hearing
Abdomen

Extremities
Lungs
Heart:
Pulse rate_____ Rhythm_____
Other findings

Blood Pressure_____

RESULTS OF DIAGNOSTIC PROCEDURES FOR TUBERCULOSIS

(Note: A negative tuberculin test or chest x-ray is required. A negative 70 mm. chest x-ray will satisfy state requirements except where a tuberculin test is positive (5 or more mm. of induration). In such instances only a 14 x 17 inch chest x-ray will be acceptable. When any chest x-ray is suspicious for tuberculosis, then additional study should be made to determine: 1. Diagnosis 2. Contagiousness (Activity).

Chest x-rays. 70 mm. ☐ Date of x-ray_____ Place taken_____
or
14 x 17 ☐ _____
Interpretation

Tuberculin Test:
P.P.D. ☐ Strength:_____

Test used: Date applied_____ Date read_____ Result_____mm. of induration

O.T. ☐ Strength:_____

Additional tuberculosis study performed as indicated in above NOTE:

14 x 17 x-ray: Date taken_____ Interpretation_____

Sputum exam: Name of Laboratory_____ Report No._____ Date of Report_____

Type of study: Smear ☐; Guinea pig inoculation ☐; Culture ☐

Result_____

Gastric fluid: Name of Laboratory_____ Report No._____ Date of Report_____

Type of study: Smear ☐; Guinea pig inoculation ☐; Culture ☐

Result_____

REPORT BELOW ANY SIGNIFICANT FINDINGS RELATED TO THE FOLLOWING OR OTHER CONDITIONS WHICH MAY INFLUENCE TEACHING EFFECTIVENESS

Allergies	Venereal Disease	Endocrine
Diabetes	Migraine	Other
Epilepsy	Muscular Incoordination	

Complete the attached recommendation and certificate form below, and detach from this examination form.

Duplicate for doctor's record on reverse side.

DETACH & RETURN TO DISTRICT SCHOOL BOARD

PHYSICIAN'S RECOMMENDATIONS AND CERTIFICATE OF EXAMINATION OF SCHOOL EMPLOYE

To _____ District School Board _____
Name — Name of Employe Examined

_____ _____
Address — Address

This will certify that I, _____, _____,
Name in Full — Address

a physician licensed and registered to practice medicine in the State of Wisconsin, completed the physical examination, x-ray and other tests required by statute on_____, 19____, and find the above named individual, known to me, to be free ☐ not free ☐ from tuberculosis in a communicable form at the time of examination. On the basis of the examination I do ☐ do not ☐ recommend the above named individual as physically suitable for employment. The employe named herein has been informed of these recommendations.

_____
(Signature of Examining Physician)

Form SCH3R

eral years. The law is administered by the Department of Public Instruction in cooperation with the State Board of Health.

The State Department of Public Instruction has interpreted "school employe" to mean everyone on the school board pay roll—administrator, teacher, clerical worker, custodian, school bus operator, school lunch worker, etc. School bus drivers not employed by the local district on a full-time basis are not included unless the district makes its own rule calling for mandatory examinations. One clear exception to the required examination is an employe who files with the board "an affidavit setting forth that he depends exclusively upon prayer or spiritual means for healing in accordance with the teachings of a bona fide religious sect, denomination or organization." However, if the board has reasonable cause to believe that such an employe is suffering from an illness detrimental to the health of school pupils, it may require a health examination of such a nature as to indicate whether or not the employe is ill. After the initial report has been filed, the board must decide as to the frequency of subsequent examination for its employes. A chest x-ray or tuberculin test must be repeated, however, at least once every three years.

The employes are to be examined by a licensed physician in the employ of or under contract with the district. However, if the board does not intend to employ or enter into contract with a physician, it may then advise employes or potential employes to select a licensed physician for the examination. The cost of the examinations is a school board expense, and the employes cannot be required to pay for them.

The examination report form was prepared by the State Board of Health and the Department of Public Instruction. The major portion of the report is retained in the physician's file, and the lower detachable part containing the doctor's recommendations is the only portion sent to the district school board. The physician's portion of the form is a confidential document not available to school employers.

It should be noted that the examination requires a negative tuberculin test or chest x-ray. Where the tuberculin test is positive, a 14 by 17 inch chest x-ray is necessary.

The examinations must be conducted by "licensed physicians," which under the terms of the law means any physicians licensed to practice medicine and surgery in Wisconsin.

In those instances where health examinations conducted under Section 40.30 (10m) (a) require the testing of vision, state law provides that this portion of the examination *may* be made by a licensed optometrist.

Section 143.16 of the Statutes requires the physical examination of employes in private and parochial schools which enroll pupils in grades 1 through 12. In this section of the Statutes the law does not specify the selection of physician, religious exemption, or the specific reporting form to be used. However, the State Board of Health is contacting all private and parochial schools and informing them of the law and the forms available to comply with it.

ORTHOPEDIC CLINICS

CONDUCTED BY THE CRIPPLED CHILDREN DIVISION, BUREAU FOR HANDICAPPED CHILDREN, the clinics listed below are for persons under 21 who are referred by their family physician for orthopedic diagnosis and consultation. Reports of the examination are sent to the referring physician following the clinic.

FORMS FOR REFERRAL may be obtained by writing Bureau for Handicapped Children, 122 West Mifflin Street, Madison 3, and should be requested well in advance of the clinic date. Medical referral forms are made up for the individual clinics so, when making requests, state number of forms needed and for which clinic or clinics.

Families who return the signed referral form will be notified of the date and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child.

Location	Date
Ashland	February 13, 14
Manitowoc	February 20, 21
Green Bay	February 27, 28
Eau Claire	March 6, 7
Racine	March 12, 13
Kenosha	March 19, 20
Wausau	March 26, 27
La Crosse	April 15, 16, 17
Sheboygan	April 23, 24
Marinette	April 30
Fond du Lac	May 14
Appleton	May 15, 16
Superior	May 19
Chippewa Falls	May 21, 22
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THE LEGAL STATUS OF A DOCTOR WITHOUT A PERMANENT LICENSE

THE preceptee and the intern are not licensed to practice medicine in Wisconsin. What duties may they legally perform? The resident has a license. Is he limited in any way? The doctor with a temporary educational certificate which he can hold for no more than three years—what are his limitations?

These fine lines of licensure have been the cause of concern to many physicians. Here is a summary of the legal standing of the physician who does not have a permanent license to practice in Wisconsin.

PRECEPTEES

The term "preceptee" or "extern" is professionally understood to refer to advanced medical students who have not as yet completed their college course in medicine. A preceptee is one who has not yet reached the intern stage. He is not licensed to practice medicine. Nevertheless, a preceptee performs certain assisting and observing functions, either during a vacation period or during his fourth year of medical study, under the supervision of a licensed physician. Preceptees participate in this portion of their training under an arrangement between supervising physicians and the medical school. The hospital has no jurisdiction over them.

A preceptee is generally an assistant of a physician. The duties delegated to a preceptee by a physician are usually very much limited, relating only to observation. Thus, a situation would seldom arise in which an act of a preceptee might cause injury. A physician presumably has the duty to see to it that the preceptee is delegated no duty which would call for discretion or judgment on his part. However, a negligent act on the part of a preceptee in the treatment of a patient is a responsibility of the physician under whom he is working.

INTERNS

An "intern" is generally understood to apply to one who is engaged in a twelve months' period of advanced study and apprenticeship immediately subsequent to the completion of his college course and prior to the granting of his license. Internship is a prerequisite for the granting of a license to practice medicine and surgery in Wisconsin. After one year of internship, unless his medical school requires a longer period of internship as a condition of graduation, the intern must be licensed and have the legal status of a practicing physician.

An intern does not have the full legal status of a licensed practitioner. He does have certain functions of a medical nature which he is permitted to perform. The Wisconsin Supreme Court has admitted that interns are not subject to the Medical Practice Act because the Wisconsin statutes require an internship as a part of one's medical education prior to licensure. The court summarized the legal status of an intern in Wisconsin as follows:

> "This is a legal sanction of the performance of such duties on the part of interns as are usually and ordinarily performed by them. The performance of such duties does not constitute the practice of medicine, or a representation that the intern is authorized to practice medicine."

Interns are not within the provisions of the so-called "medical privilege statute."

When it comes to responsibility for negligence of interns while performing their customary duties, it is clear that they have a personal responsibility. The responsibility for their acts, however, may extend to the physicians under whom they are working, or to the hospital employing them. The law generally holds the intern to be an employee or servant, inasmuch as he is obliged to spend his days and nights at the hospital to render any administrative or medical service provided by the hospital through its agents, within the range prescribed by propriety and custom. This interpretation of his position is recognized by the courts under the Workmen's Compensation Act, which extends employee protection to interns injured in the performance of their duties in the hospital.

Wisconsin has held that the hospital is responsible for liability arising out of the acts of interns in the performance of duties which are customarily performed by them. Exemption, however, has been made in the case of charitable hospitals which are protected by law for the acts of their employees or servants. However, where the intern is acting under the direct supervision of a physician during the course of an operation, the hospital is absolved from responsibility and his acts become those of the physician who has charge of the work.

HOLDERS OF TEMPORARY EDUCATIONAL CERTIFICATES

The 1953 legislature provided for the granting of "temporary educational certificates" to certain physicians who wish to take advantage of postgraduate education in Wisconsin but who are otherwise unable to meet the licensure requirements of the state. Such a certificate entitles the physician to take post-

graduate educational training in an accredited teaching hospital. These certificates are normally issued for only one year, but may be renewed for an additional two years. Any person holding a temporary educational certificate must act under the direction of a person licensed to practice medicine and surgery in Wisconsin.

Under such direction, the holder of a temporary educational certificate has the right to prescribe drugs other than narcotics and to sign any certificates, reports, or other papers for the use of public authorities which are expected of a regularly licensed physician. Likewise, under supervision he may perform those services required for the completion of his postgraduate educational training.

These certificate holders must confine their training and practice to the hospital in which they are taking postgraduate education. Neither they nor the hospital may receive any fees or other income for their services from any patients treated by them during the course of training.

RESIDENTS

A "resident" is usually understood to mean a person engaged in postgraduate medical education beyond the period of internship. In any event, a resident is required to hold a regular, permanent license to practice medicine. He is as fully responsible for his acts or omissions as any other licensed practitioner.

HOLDERS OF TEMPORARY LICENSES

Since the State Board of Medical Examiners holds its regular sessions only four times a year, provision has been made for the granting of temporary licenses to physicians whose services are needed in the state but who otherwise would have to wait for several months for licensure.

The temporary license may be granted to an applicant for a permanent license if he has met all the requirements for licensure but there are more than 30 days before the next meeting of the Board. Such applicants must be graduates of Marquette University School of Medicine or the University of Wisconsin Medical School, or must be already licensed to practice medicine and surgery in another state. All such persons must meet the regular licensing requirements, and their application for temporary license may be approved by any two of the officers of the Board of Medical Examiners if they find "that an emergency need exists for medical personnel in a particular area." In determining that an emergency exists, the Board must consider the particular health standards of the area and the possible detrimental effects resulting from not filling the reported need for additional medical personnel.

The temporary license expires 30 days following the next examination for a permanent license or on the day, following the applicant's examination, on which the Board grants or denies him a permanent license, whichever occurs first. The physician who has a temporary license is privileged to practice in the same manner as a permanently licensed physician.

Licensing of Foreign-Trained Physicians

THE 1957 Legislature made provision for the permanent licensing of certain foreign-trained physicians who come to Wisconsin.

The legislation was developed to permit Wisconsin to accept certain highly qualified individuals trained in foreign medical schools who might otherwise be unable to practice in the state. It is intended basically as an interim device to the creation by the American Medical Association and other national licensing agencies of a national and international screening system for foreign-trained medical school graduates.

Under the new law, Section 147.15 (1m) of the Statutes, certain foreign-trained applicants may be granted a permanent license provided they meet certain educational prerequisites.

Such applicants must have professional qualifications through recognized postgraduate work done in this country or through professional experience or both which give them premedical training substantially equivalent to that offered in the premedical course at the University of Wisconsin or professional training substantially equivalent to that of the University of Wisconsin or both. When the State Board of Medical Examiners is satisfied as to an applicant's equivalent premedical and medical training, the license may be granted. In the course of ascertaining the individual's training, the dean of any medical school approved and recognized by the Board must examine the premedical and medical qualifications of the applicant and state that the applicant meets the present standards for graduates of the professional school which he heads. No more than 25 licenses a year can be issued under the Statute and it expires on July 1, 1961.

Adoptions and Child Placement

WISCONSIN law specifically prohibits physicians, as well as other nonauthorized persons, from acting as intermediaries in finding children for adoption or making placements. In fact, no person and no parent or guardian except a licensed child welfare agency or public agency authorized to place children for adoption may place a child in a foster home for adoption without obtaining the written approval of the county court.

This means that a physician may not suggest to any unmarried mother, other natural parent, or legal guardian any particular foster parents for a child he believes available for adoption. The physician may not offer to find foster parents for such a child. He may not offer to find a child for adoption by prospective foster parents nor may he place a child with foster parents on a trial or any other basis. He may not act in any other way as negotiator or intermediary in such matters.

Stiff penalties back up the law: fines up to $500, or imprisonment up to one year in the county jail, or both.

The physician is advised to urge the unwed mother, prospective parents, or others to consult with either a licensed child welfare agency or an authorized public agency. If questions arise the physician should consult the Division for Children and Youth, 311 State Street, Madison 3, Wisconsin, the state administrative agency charged with adoptions.

Child placement cases may be referred to the agencies listed at the right.

Professional reputation and ethical standing, as well as a police record, are at stake in the physician's dealings with the unwed mother or prospective parents. Thus, it is absolutely essential that he avoid any conduct which might cause the public to view him as associated with a "black market in babies."

It may help the physician to know that the declared policy of the State of Wisconsin gives paramount concern to the welfare of the child in any adoption procedure. The parents, guardian, and the public interest have secondary consideration. Thus, the Children's Code, by insisting on referral of adoption cases to authorized agencies, offers the physician practical and highly professional recourse in what might otherwise be a dangerous sentimental action.

REFER CHILD PLACEMENT CASES TO THESE AGENCIES

Licensed Child Welfare Agencies:

*Children's Service Society of Wisconsin, 610 North Jackson, Milwaukee 2.

Catholic Social Welfare Bureau, 2018 North Oakland Avenue, Milwaukee 2.

Catholic Welfare Agency, 1200 15th Avenue East, Superior.

Catholic Welfare Bureau, 3222 South Avenue, La Crosse.

Catholic Welfare Bureau, 119 East Washington Avenue, Madison 3.

Green Bay Diocese Apostolate (Catholic), 131 South Madison Street, Green Bay.

Lutheran Children's Friend Society, 8138 Harwood Avenue, Wauwatosa.

Lutheran Welfare Society of Wisconsin, 3126 West Highland Boulevard, Milwaukee 8.

Jewish Family and Children's Service, 2218 North Third Street, Milwaukee 12.

Public Agencies:

*Wisconsin Division for Children and Youth, 311 State Street, Madison 3.

*Milwaukee County Child Welfare Division, County Court House, Milwaukee 3.

Licensed Maternity Homes:

*Martha Washington Home, 6306 Cedar Street, Wauwatosa.

Misericordia Hospital (Catholic), 2224 West Juneau Street, Milwaukee 8.

St. Ann's Maternity Annex (Catholic), 1020 Market Street, La Crosse.

St. Mary's Home (Catholic), 403 South Webster Avenue, Green Bay.

*Summit Hospital, Oconomowoc.

Fees for care in licensed maternity homes vary from $80 to $150, covering prenatal care, confinement, and care after the child is born. Several institutions provide employment opportunities to cover the cost of service rendered. Counseling services for unwed parents, both before and after the birth of the child, are provided by social agencies.

* Nondenominational.

YOUR DEADLINES AND OTHER "MUSTS"

Below are some of the deadlines and "musts" of a practicing physician:

Taxes

1. By January 15, 1958, you must pay the final installment of the estimated federal tax on your 1957 income. This may necessitate an amended declaration by that date if you find that you underestimated 1957 income. A final income tax return for 1957, filed before January 31, 1958, will be treated as the equivalent of an amended declaration as of January 15. Penalties are assessed for certain underestimating of taxes. These penalties and their legal avoidance are discussed in Section 5 below.
2. By January 31, you must:
   (1) File the employer's final return of income taxes withheld in 1957 on Form W–3.
   (2) Furnish a statement to employees on Form W–2 showing wages paid and amount of tax withheld during the calendar year 1957.
   (3) File fourth quarterly return for 1957 of income and social security tax withheld on wages paid employees on Form 941 if:
      (a) The entire tax was not paid by timely depositary receipts for all three months of the preceding quarter; or
      (b) Less than $100 was withheld in each of the months of October, November, and December, 1957.
   (4) Pay income and social security taxes withheld on 1957 wages of employees if:
      (a) More than $100 was withheld in December, 1957, and not paid to government depositary earlier in January, 1958; or
      (b) Less than $100 was withheld in each of the months of October, November, and December, 1957.
3. Miscellaneous:
   (1) If the total of income and social security tax withheld on employees' wages exceeds $100 a month in each of the three months of the preceding calendar quarter, and payments were made to a government depositary previous to the fifteenth of the next month, the quarterly return on Form 941 should be filed on or before the tenth of February, May, August, and November, as the case may be.
   (2) If instructions contained in paragraphs (3) and (4) of Section 2 preceding are applicable to your situation, make similar quarterly payments and returns on April 30, July 31, and October 31, 1958, for the respective preceding calendar quarters.
   (3) If income and social security taxes withheld on employees' wages exceed $100 in either the first or second months of each calendar quarter, the amount thereof should be paid to a government depositary by the fifteenth of the following month. The amount of such withheld taxes for the last month of each quarter may either be paid to a government depositary by the fifteenth of the month immediately following or may accompany the quarterly return if the latter is filed by the end of the month following such calendar quarter.
4. File your Wisconsin and federal partnership and personal income tax returns as early in 1958 as possible, but no later than April 15. State returns should be filed with the assessor of incomes in the district in which you live, Federal returns with the Director of Internal Revenue, Milwaukee.
5. Estimates of Income; Quarterly Adjustments; Penalties.
   The first quarterly estimate of your 1958 income must be shown on a federal declaration form which has to be filed, together with the estimated tax due, by April 15, 1958. Other installments of the tax are due, together with amendments in the declaration should there be a change upward or downward, by June 15, and September 15, 1958. As to the final payment or amendment of declaration due in January, 1959, follow the alternative procedure described in Section 1 above.

Excluding cases of wilful understatement, interest penalties are provided for underestimating and thus underpaying taxes on declaration of estimated income, to the extent that each quarterly installment is under 70 per cent of one-fourth of the tax due for the year, as shown on the filed return. A penalty of 6 per cent computed on the amount of the underpayment from the due date of a particular installment is added to the tax. The penalty can be legally avoided in either of two ways. The first is to base the estimated tax upon the previous year's income at 1958 tax rates and exemptions in force at the time a particular installment is being paid, or to base quarterly payments on the previous year's tax, whichever is the lesser. The second is to follow the so-called "90 per cent rule." This is a rather complicated formula, and each physician who cares to follow it should consult his attorney or tax accountant.

Annual Registration in Wisconsin; Annual Narcotics Registration

1. Register with the Secretary of the Wisconsin State Board of Medical Examiners, Room 1140, State Office Building, 1 West Wilson Street, Madison 3, in the month of January. This registration will be on a form furnished by the Board of Medical Examiners.
2. Register as required by the federal narcotics law, and pay the annual tax *before* July 1, 1958. You are subject to penalties for overlooking either the registration or the tax.

Change of Residence:

1. Notify the Director of Internal Revenue, Milwaukee, Wisconsin, to insure the legality of your narcotics license. Penalties are imposed for failure to do this.

Remember to:

1. Make prompt report to the State Board of Health, State Office Building, 1 West Wilson Street, Madison 3, of cancer cases, communicable diseases and others.
2. File with the city health officer or county register of deeds a certificate for all births attended by you within five days of the event. Otherwise your medical fees are unlawful. Sec. 69.30, statutes.
3. Register with the county judge if you desire reference work on commitment proceedings for persons allegedly mentally ill, mentally infirm, mentally deficient, inebriate, or drug addicts.
4. Notify the next of kin or a person who may be chargeable with the funeral expenses before you send, or cause to be sent, the corpse of any deceased person to a funeral director, undertaker, mortician, or embalmer. The penalty is severe for failure to do so. Secs. 156.14; 156.15 (1), statutes.
5. Report *immediately* the following deaths, as required by Section 366.20, statutes, to the sheriff, police chief, or coroner of the county in which such death occurred:
   a. All deaths in which there are unexplained, unusual, or suspicious circumstances.
   b. All homicides.
   c. All suicides.
   d. All deaths following an abortion.
   e. All deaths due to poisoning, whether homicidal, suicidal, or accidental.
   f. All deaths following accidents, whether the injury is or is not the primary cause of death.
   g. When there is no physician in attendance.
   h. When a physician refuses to sign the death certificate.

Federal and Wisconsin Unemployment Compensation Liability.

See in this connection the text of the box on page 47 of this issue.

PRINCIPLES OF MEDICAL ETHICS of the AMERICAN MEDICAL ASSOCIATION

PREAMBLE

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1.—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2.—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Section 3.—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

Section 4.—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Section 5.—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

Section 6.—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Section 7.—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

Section 8.—A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

Section 9.—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Section 10.—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

Adopted June 7, 1957

GROWTH OF PATHOLOGY SERVICE IN WISCONSIN

THERE were apparently no specialized practitioners of pathology in Wisconsin until shortly after the turn of the century, when Dr. Daniel Hopkinson, a graduate of Milwaukee Medical College, established a laboratory in Milwaukee and provided pathology service, principally autopsies, to a number of hospitals. At about the same time Dr. Hjolifeur Khristjansen became pathologist at the Milwaukee County Hospital and made his services available, on a part-time basis, to other local institutions. In 1912, Dr. Christobol Manalang joined Dr. Hopkinson and was followed by Dr. Edward Tharinger in 1914. In 1913 Dr. Albert F. Boretti became the first professor of pathology at the newly organized Marquette University School of Medicine. He was followed by Drs. F. A. McJunkin (1914–21), D. Hopkinson (1922–23), E. Miloslavich (1923–28), John Schaefer (1929–30), M. Fernan-Nunez (1931–44), J. Grill (1944–45), W. A. D. Anderson (1946–53), and J. F. Kuzma.

There was a simultaneous development of pathology service at the University of Wisconsin in Madison with Dr. C. H. Bunting taking the chair of pathology in 1908. Doctor Bunting was followed as professor by the current professor, Dr. D. Murray Angevine, in 1945. Dr. William D. Stovall joined the University of Wisconsin Medical School staff shortly after Doctor Bunting as bacteriologist in the newly organized State Laboratory of Hygiene. He was made director of the laboratory in 1914, a position which he holds to this day. Doctor Stovall has offered the services of this laboratory to physicians of the state but at the same time has encouraged the establishment and utilization of local pathology services wherever possible. Doctor Stovall made several attempts before 1928 to stimulate interest in a state organization of pathologists. At his suggestion, Dr. Joseph Bloodgood, and later Dr. Max Cutler, were invited to Madison to conduct slide seminars (known as slide clinics in those days); however, not enough interest was shown at that time to form an organization.

EARLY SERVICES OF PATHOLOGISTS

During these early days in the development of pathology the primary function of the pathologist was the performance of autopsies with a gradual expansion into surgical pathology. There was very little practice of clinical pathology as we know it today. There were no medical technologists and usually the tissue preparations and other laboratory work were done by the pathologist himself.

WISCONSIN PATHOLOGY SOCIETY

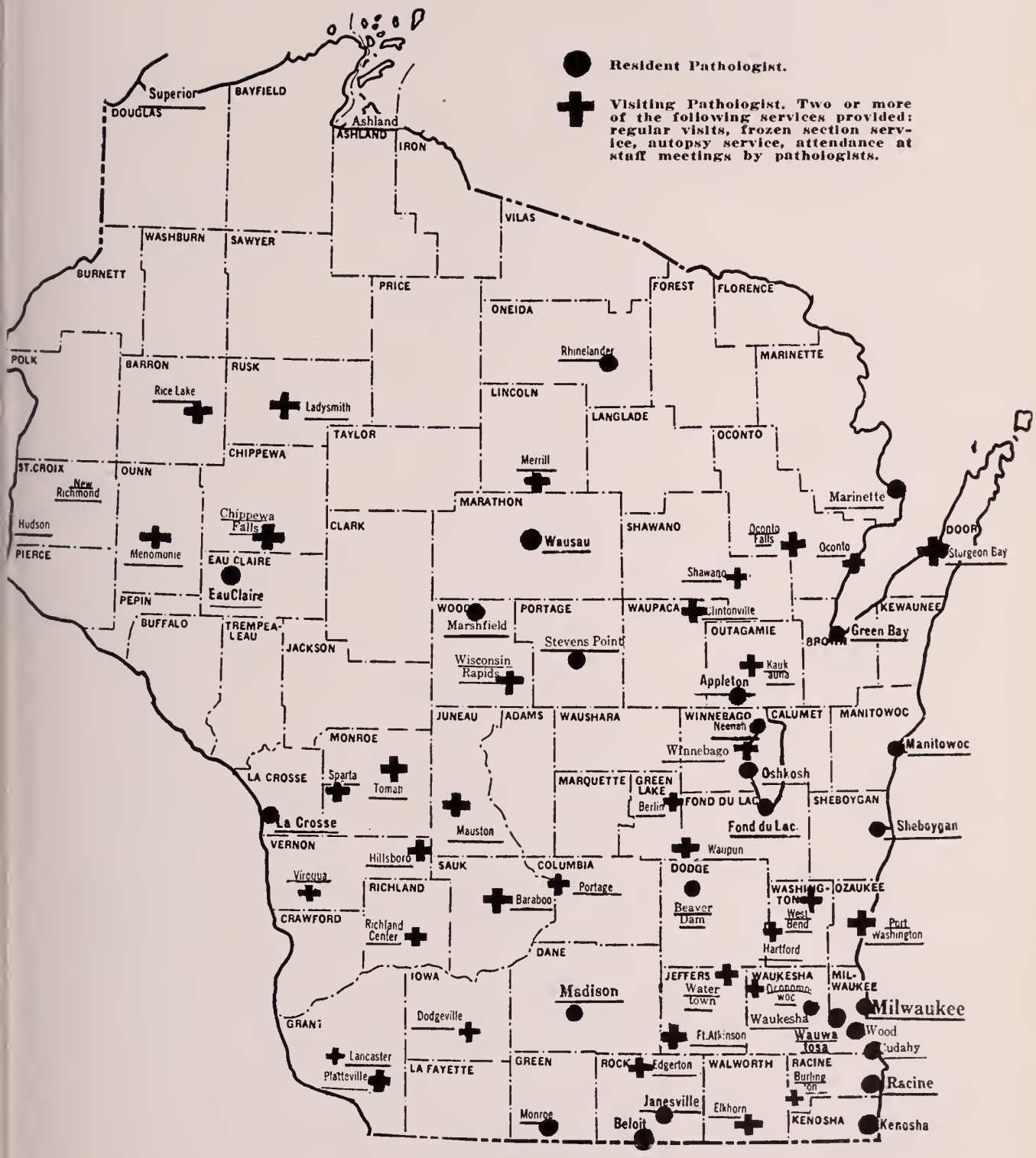
May 15, 1932, the Milwaukee Pathology Society was organized and founded by Drs. J. J. Seelman, N. Enzer, E. L. Tharinger, E. F. Barta, E. J. Oesterlein, J. Grill, and M. Fernan-Nunez. Ten years later, in 1942, the society's name was changed to the Wisconsin Society of Pathologists in recognition of the fact that the number of pathologists in the state outside of Milwaukee and Madison was steadily increasing. All pathologists were invited to join the society. The group continued to grow so that by October, 1951, when the Section on Pathology of the State Medical Society of Wisconsin was established, there were 48 practicing pathologists in the state.

At the present time the Wisconsin Society of Pathologists has a membership of 70. The wide geographic distribution of these pathologists is indicated on the accompanying map.

PATHOLOGY SERVICE TODAY

Clinical pathology service today is recognized as the cornerstone upon which all good clinical medicine depends, and the pathologist on the medical staff serves as a constant stimulus to scientific progress. The generalist or specialist, wherever located, is as insistent today on rapid, precise, and exact diagnosis as is his metropolitan colleague, and like his big-city colleague, he wants to discuss the implications of the laboratory reports with an on-the-scene pathologist. The increasing number of clinical pathologists located in the less populous areas of Wisconsin is a reflection of the growing demand for consultation in everyday practice and of the realization that more than mere technical skills must be found in a clinical laboratory. Wherever a pathologist is active, the small, one-room, one-technologist hospital laboratory becomes an instrument of precision where both simple and more complex laboratory procedures are available, and their proper selection and interpretation are emphasized in the best interest of the patient's welfare. The majority of pathologists operating hospital laboratories make their services available to private ambulatory patients as well as to in-hospital patients. With an increase in the number of practicing pathologists and the spread of service rendered by them to nearly every section of the state, adequate coverage and consultation are as close to every physician as the telephone on his desk. This service in most areas of the state includes, in addition to the accepted routine clinical laboratory procedures, all commonly requested chemical procedures, many immunologic studies, and surgical tissue and cytologic examinations. Viral studies and more complicated bacteriologic procedures concerned with epidemiologic control of disease are usually referred to the proper public health agencies.

The performance of tests at the local level results in rapid and accurate diagnosis because it allows ready consultation between the attending physician and the pathologist. In addition, utilization of local diagnostic facilities results in the improvement and extension of laboratory services and the develop-



Map indicating geographic distribution of pathologists in state (see pp. 70–71 for list of names). In the cities underlined only (Superior, Hudson, Ashland, and New Richmond) hospitals are serviced by out-of-state pathologists.

ment, trial, and adoption of new tests which at first seem to have but limited application. An increase in the volume of laboratory work allows the laboratory to underwrite research projects and part-pay or free service for the needy. Members of the Section on Pathology make charges in keeping with the needs of the patient and in line with the charges made by the attending physician. The pathologists of the state have pledged their services in the thorough study of maternal and fetal deaths in cooperation with the Division on Maternal and Child Welfare.

Wisconsin Pathologists Serving the State

Altshuler, Charles H.	St. Joseph's Hospital	Milwaukee
Angevine, D. Murray	University of Wisconsin Medical School	Madison
	University of Wisconsin Hospitals	Madison
Bareta, John	St. Joseph's Hospital	Milwaukee
Barta, Edward F.	425 East Wisconsin Avenue	Milwaukee
Bartholomew, Richard D.	Shawano Municipal Hospital	Shawano
	Clintonville Community Hospital	Clintonville
	Holy Cross Hospital	Merrill
Birge, Edward A.	Milwaukee Hospital	Milwaukee
Blackburn, Marvin D., Jr.	Bellin Memorial Hospital	Green Bay
Blake, William J.	St. Luke's Hospital	Milwaukee
Brucker, Edward A., Jr.	St. Mary's Hospital	Madison
Carlson, David J.	Milwaukee Hospital	Milwaukee
	Oconomowoc Memorial Hospital	Oconomowoc
Cauldwell, Earl W.	Beloit Municipal Hospital	Beloit
Clarke, B. Earl	St. Luke's Hospital	Milwaukee
Claudon, D. B.	Columbia Hospital	Milwaukee
	Milwaukee Children's Hospital	Milwaukee
Conlon, Harold	Luther Hospital	Eau Claire
	Memorial Hospital	Menomonie
	St. Mary's Hospital	Ladysmith
	Lakeside Methodist Hospital	Rice Lake
Connors, Dean	St. Mary's Hospital	Rhinelander
*Cooper, George W.	U. S. Veterans Administration Hospital	Tomah
	St. Luke's Hospital	Milwaukee
Cyrus, Andrew E., Jr.	Veterans Administration Hospital	Wood
Dietz, Paul C.	St. Francis Hospital	La Crosse
	La Crosse Hospital	La Crosse
	St. Joseph's Memorial Hospital	Hillsboro
	St. Mary's Hospital	Sparta
	Tomah Memorial Hospital	Tomah
	Vernon Memorial Hospital	Viroqua
	Mauston Hospital	Mauston
Enzer, Norbert	Mount Sinai Hospital	Milwaukee
Eigenberger, Friedrich	Sheboygan Memorial Hospital	Sheboygan
Erchul, James W.	St. Elizabeth Hospital	Appleton
Erwin, Chesley P.	Marquette University School of Medicine	Milwaukee
	Doctor's Hospital	Milwaukee
	Lakeland Hospital	Elkhorn
Falsetti, Frank P.	Misericordia Hospital	Milwaukee
Fink, Robert J.	Sacred Heart Hospital	Eau Claire
	St. Joseph's Hospital	Chippewa Falls
Fodden, John H.	Mount Sinai Hospital	Milwaukee
Ford, John L.	St. Vincent's Hospital	Green Bay
Fox, Gerald E.	St. Michael's Hospital	Stevens Point
Glassy, Frank J.	St. Joseph's Hospital	Marshfield
Harrold, Bruce D.	St. Clare Hospital	Monroe
Hartmann, Henrik A. L.	University of Wisconsin Medical School	Madison
	Mendota State Hospital	Madison
Haukohl, Robert S.	Deaconess Hospital	Milwaukee
	St. Joseph's Hospital	West Bend
Heitzman, H. H.	St. Mary's Hospital	Green Bay
Hillenbrand, H. Melvin	Mercy Hospital	Oshkosh
	Winnebago State Hospital	Winnebago
Holt, Stephen H.	Kenosha Hospital	Kenosha
	St. Catherine's Hospital	Kenosha
Jaeck, James L.	Gundersen Clinic	La Crosse
	La Crosse Lutheran Hospital	La Crosse
	Grandview Clinic	La Crosse
Jaeschke, Walter H.	University of Wisconsin Hospitals	Madison
	University of Wisconsin Medical School	Madison

Kelley, Orville R.	808 Third Street	Wausau
	St. Mary's Hospital	Wausau
	Marathon County Blood Bank	Wausau
Kurtin, Joseph J.	Trinity Hospital	Cudahy
	St. Francis Hospital	Milwaukee
Kuzma, Joseph F.	Marquette University School of Medicine	Milwaukee
	Lakeland Hospital	Elkhorn
Lalich, Joseph J.	University of Wisconsin Medical School	Madison
*Lindner, Anton	State Laboratory of Hygiene	Madison
Llewellyn, M. B.	Mercy Hospital	Janesville
	Ft. Atkinson Memorial Hospital	Ft. Atkinson
	Memorial Community Hospital	Edgerton
Lubitz, Joseph M.	St. Francis Hospital	Milwaukee
	Veterans Administration Hospital	Wood
Lunseth, John H.	Milwaukee County General Hospital	Wauwatosa
Maynard, Russell	Veterans Administration Hospital	Wood
McGary, Lester	Madison General Hospital	Madison
	Divine Savior Hospital	Portage
	Dodgeville General Hospital	Dodgeville
	Memorial Hospital	Dodgeville
	St. Joseph's Hospital	Dodgeville
	St. Mary's-Ringling Hospital	Baraboo
Olson, Ernest S.	St. Luke's Hospital	Racine
	Burlington Memorial Hospital	Burlington
Pessin, Samuel B.	St. Mary's Hospital	Milwaukee
	St. Mary's Hospital	Watertown
Piper, Philip G.	Madison General Hospital	Madison
Richards, William	113 West Maple Avenue	Beaver Dam
	St. Joseph's Hospital	Beaver Dam
	Lutheran Hospital	Beaver Dam
	Waupun Memorial Hospital	Waupun
Ritchie, Gorton	Columbia Hospital	Milwaukee
	Milwaukee Children's Hospital	Milwaukee
Rogers, Raymond J.	Marinette General Hospital	Marinette
	Door County Memorial Hospital	Sturgeon Bay
	Oconto County and City Hospital	Oconto
	Oconto Falls Community Memorial Hospital	Oconto Falls
*Rosenthal, Samuel	John Mariner Building	Milwaukee
	St. Joseph's Hospital	Hartford
Schafer, Etheldred	Jackson Clinic	Madison
	Methodist Hospital	Madison
	Richland Hospital	Richland Center
Schoene, Fred	Waukesha Memorial Hospital	Waukesha
	Veterans Administration Hospital	Waukesha
Schuster, Myron	St. Mary's Hospital	Racine
Schwab, Robert L.	Theda Clark Memorial Hospital	Neenah
	Kaukauna Community Hospital	Kaukauna
Steube, R. W.	St. Agnes Hospital	Fond du Lac
Stovall, William D.	Wisconsin State Laboratory of Hygiene	Madison
	University of Wisconsin Hospitals	Madison
Strand, Clarence M.	Lancaster Memorial Hospital	Lancaster
	Platteville Municipal Hospital	Platteville
*Taira, Yoshiro	Deaconess Hospital	Milwaukee
Teresi, Joseph L.	St. Michael Hospital	Milwaukee
	Medical Examiner, Milwaukee County	
Van Hecke, L. J.	161 West Wisconsin Avenue	Milwaukee
	St. Alphonsus Hospital	Port Washington
Venables, A. J.	Wausau Memorial Hospital	Wausau
	Riverview Hospital	Wisconsin Rapids
Vernon, Robert	Lancaster Memorial Hospital	Lancaster
	Platteville Municipal Hospital	Platteville
Voet, Raymond	St. Mary's Hospital	Milwaukee
Wood, Hobart	St. Nicholas Hospital	Sheboygan
	Holy Family Hospital	Manitowoc
	Memorial Hospital	Manitowoc
Worley, Gordon	1010 Yale Road	Madison
Ziehl, Frank	St. Anthony's Hospital	Milwaukee
	Mercy Hospital	Milwaukee
*Zu Rhein, Gabriele M.	University of Wisconsin Medical School	Madison

* Associate member of Wisconsin Society of Pathologists.

In addition to the above, pathologists from Minnesota service the hospitals in Superior, Hudson, Ashland, Rice Lake, and New Richmond.

Officers of State Boards and Commissions

State Board of Health

Members of the Board

Samuel L. Henke, M. D., President, Eau Claire, 1960

Carl D. Neidhold, M. D., Vice-President, Appleton, 1959

Carl N. Neupert, M. D., M.S.P.H., Secretary, Madison

William T. Clark, M. D., Janesville, 1963

Forrester Raine, M. D., Milwaukee, 1961

John S. Hollingsworth, D. D. S., Sheboygan, 1958

Joseph C. Griffith, M. D., Milwaukee, 1962

Elizabeth Baldwin, M. D., Marshfield, 1964

Bureaus, Divisions, and Units of State Board of Health

Carl N. Neupert, M. D., M.S.P.H., State Health Officer

E. H. Jorris, M. D., M.S.P.H., Assistant State Health Officer

Section on General Administration

E. H. Jorris, M. D., M.S.P.H., Director

Division of Staff Services—E. H. Jorris, M. D., M.S.P.H., Director

Division of Personnel—Henry Kjentvet, B.S., Director

Division of Statistical Services—Paul Weis, Acting Director

Division of Fiscal Services—Fred E. Brown, Ph.B., C. P. A., Director

Division of Internal Services—Lenore Brandon, Supervisor

Division of Laboratories—W. D. Stovall, M. D., Director

Bureau of Vital Statistics—Paul Weis, Assistant State Registrar

Division of Dental Education—Francis A. Bull, D. D. S., M.S.P.H., Director

Division of Health Education—Luida Sanders, B.A., Director

Division of Hospital and Related Services—Vincent F. Otis, Director

Division of Cosmetology—Kathleen Bower, Supervisor

Division of Barbering—Thomas D. Ritchie, Supervisor

Division of Funeral Directing & Embalming—Helen Kjelson, Supervisor

Division of Hotels and Restaurants—Harold E. Olsen, Supervisor

Section on Preventable Diseases

Milton Feig, M. D., M. P. H., Director

Bureau of Communicable Diseases—Milton Feig, M. D., M. P. H., Director

Division of Tuberculosis Control—Milton Feig, M. D., Acting Director

Division of Venereal Disease Control—A. L. Van Duser, M. D., M. P. H., Director

Division of Cancer Control—A. L. Van Duser, M. D., M. P. H., Director

Division of Heart Disease Control—Milton Feig, M. D., M.P.H., Acting Director

Section on Environmental Sanitation

O. J. Muegge, M. S.—State Sanitary Engineer

Harvey Wirth, B. S.—Assistant State Sanitary Engineer

Bureau of Sanitary Engineering—Harvey Wirth, B. S., Director

Division of Plumbing—Walter Spencer, Supervisor

Division of Well Drilling—Thomas Calabresa, M. S., Supervisor

Division of Rendering and Slaughtering—Harold L. Johnson, Supervisor

Division of Water Pollution Control—T. F. Wisniewski, B. S., Director

Section on Maternal and Child Health

Amy Louise Hunter, M. D., Dr. P. H., Director

Bureau of Maternal and Child Health—Amy Louise Hunter, M. D., Dr. P. H., Director

Division of Child Guidance—A. B. Abramovitz, M.A., Director

Division of Nutrition—Lucile K. Billington, M. S., Supervisor

Section on Local Health Administration

Allan Filek, M. D., M. S. P. H., Director

Bureau of Public Health Nursing—Janet Jennings, R. N., M. A., Director

Division of Industrial Hygiene—William L. Lea, Ph.D., Director

Division of Local Health Administration—Allan Filek, M. D., M. S. P. H., Director

District Health Offices

No. 1—602 Insurance Building; Phone Alpine 6-4411, Extensions 2248 and 2249, Madison

No. 2—9 West Walworth; Phone Parkview 3-3223, Elkhorn

No. 3—146 Forest Avenue; Phone 4055, Fond du Lac

No. 4—P. O. Box 251, 114½ South Water Street; Phone 566, Sparta

No. 5—City Hall, P. O. Box 270; Phone 685, Wisconsin Rapids

No. 6—605 South Adams Street, Box 383; Phone Hemlock 7-8727, Green Bay

No. 7—417½ North Bridge Street; Phone Park 3-6642, Chippewa Falls

No. 8—Court House, Box 269; Phone Forest 2-2308, Rhinelander

State Board of Public Welfare

(Created by act of 1939 legislature to supplant the State Board of Control and combine certain other agencies; reorganized by act of 1949 legislature.)

Members of the Board

W. D. Stovall, M. D., chairman, Madison, 1961
Mr. Harold W. Story, vice-chairman, Milwaukee, 1963
Mrs. C. R. Beck, secretary, West Allis, 1963
William H. Studley, M. D., Milwaukee, 1959
Mrs. Harrison L. Garner, Madison, 1959
Mr. Ralph Uihlein, Milwaukee, 1963
Mrs. Karl Kleinpell, Cassville, 1961
Mr. Leo Jelinske, Shawano, 1961
Mr. Earl M. Hale, Eau Claire, 1959

Executive Staff

Mr. Wilbur J. Schmidt, Madison, Director
Mr. George M. Keith, Madison, Deputy Director

Division of Corrections
Mr. Sanger B. Powers, Madison, Director

Division of Mental Hygiene
Leslie A. Osborn, M. D., Madison, Director

Division of Public Assistance
Mr. Thomas J. Lucas, Sr., Madison, Director

Division of Business Management
Mr. Kurt J. Kasper, Madison, Director

Division for Children and Youth
Mr. Frederick DelliQuadri, Madison, Director

Basic Science Examiners

Prof. George G. Town, President, University of Wisconsin Chemistry Department, Madison, Wisconsin, 1959
Prof. W. H. Barber, Secretary, Ripon College, 621 Ransom Street, Ripon, Wisconsin, 1963
Prof. B. H. Kettelkamp, Wisconsin State College, 429 Crescent Street, River Falls, Wisconsin, 1961

State Board of Medical Examiners

F. A. Ross, M. D., President, 2301 North Fortieth Street, Milwaukee, 1959
Thos. W. Tormey, Jr., M. D., Secretary, 1140 State Office Building, Madison, 1959
R. S. Hirsch, M. D., 318 South Main Street, Viroqua, 1961
E. C. Murphy, D. O., 438 Gilbert Avenue, Eau Claire, 1957
J. W. McRoberts, M. D., 1011 North Eighth Street, Sheboygan, 1959
E. H. Pawsat, M. D., 44 South Marr Street, Fond du Lac, 1959
Millard Tufts, M. D., 208 East Wisconsin Avenue, Milwaukee, 1961
C. A. Olson, M. D., Baldwin, 1961

Wisconsin Industrial Commission

Members of the Commission

Mr. R. G. Knutson, Madison, Chairman, 1963
Mr. A. W. Enright, Madison, 1959
Mr. John H. Rouse, Madison, 1961
Miss Helen E. Gill, Madison, Secretary

Workmen's Compensation Department
Mr. R. E. Gintz, Director

Unemployment Compensation Department
Mr. Paul R. Raushenbush, Director

Safety and Building Department
Mr. Roger Ostrem, Director

Woman and Child Labor Department
Mr. Douglas Ajer, Director

State Board of Vocational and Adult Education

E. J. Fransway, Employee member, 1963 _Milwaukee
Mrs. Erna Cartwright,
Employee member, 1959 _____Oshkosh
Frank C. Horyza, Employee member, 1959 _Superior
Alfred A. Laun, Employer member, 1959 _____Kiel
W. C. Van Cleaf,
Employer member, 1961 _____Milwaukee
Henry Herried, Employer member, 1960 ____Racine
John Last, Farmer member, 1961 _____Lake Mills
Ray Heinzen, Farmer member, 1963 ____Marshfield
Elmer Wilkins, Farmer member, 1961 ____Platteville
G. E. Watson, ex officio _____Madison
R. G. Knutson, ex officio _____Madison
C. L. Greiber, State Director, State Board of Vocational and Adult Education, 14 North Carroll Street _____Madison

Rehabilitation Division

State Office
14 North Carroll Street, Madison

John A. Kubiak_____Chief
J. H. Brown_____Assistant Chief
Charles Beardsley
_____Guidance, Training and Placement
Irene M. Dunn_Finances and Mentally Handicapped
A. E. Towne_____Medical Service
Mrs. Mary F. Beyer_____Homecraft
Edward J. Pfeifer_____Psychological Service
Milton Feig, M. D.
_____Medical Administrative Consultant (State Board of Health)
Mrs. Inez F. Belyea
_____Social Work Supervisor (Medical)
Mrs. Thelma Peckham_____Statistician

District Offices

Madison_____Vocational School Building, 211 North Carroll Street, Room 458
C. D. Rejahl, District Supervisor
Milwaukee—Vocational School Building, 1015 North Sixth Street, Room 222
Kenneth M. Kassner, District Supervisor
Green Bay—Vocational School Building, 200 South Broadway
A. W. Bouffard, District Supervisor
Eau Claire_____8½ South Farwell Street
Melvin J. Chada, District Supervisor

Local Offices

La Crosse—Vocational School Building
Carl J. Haase, Case Supervisor
Racine_____828 Center Street
V. C. Bryan, Case Supervisor
Wausau—Vocational School Building
L. J. Schultz, Case Supervisor
Superior_____917 Tower Avenue
LeRoy Forslund, Case Supervisor

DIVISION ON REHABILITATION OF COMMISSION ON STATE DEPARTMENTS

Robert Boyle, M. D._____Milwaukee
P. J. Collopy, M. D._____Milwaukee
E. P. Roemer, M. D._____Madison
R. L. Gilbert, M. D._____La Crosse
C. E. Koepp, M. D._____Marinette

S. M. S. FOUNDATION

The Charitable, Educational, and Scientific Foundation of the State Medical Society of Wisconsin continues to grow and expand its activities. Two scientific institutes on inhalation therapy were held in 1957. A research project on hearing loss being conducted at the University of Wisconsin Medical School is well under way. A study of the insurance needs of the aging is beginning. Restoration of the Fort Crawford Military Hospital and the development of the Medical Museum of Wisconsin at Prairie du Chien is moving ahead rapidly. More than $30,000 in loans to medical students has made a substantial contribution to medical education.

The S.M.S. Foundation appeals to all active members of the Society for annual contributions of $10 or more. Since 1954 these appeals have brought more than $23,000 in contributions. In addition, contributions from foundation or corporate sources have totaled nearly $25,160 since 1954.

The Foundation looks to both physicians and the public for contributions. The physician is solicited annually but may make his contribution in a number of ways: by a yearly donation at the time of solicitation or through a will, a commemorative gift, or a carefully directed and earmarked offering.

Contributions to the Foundation are deductible by the donor in computing his taxable income.

Physicians are encouraged to advise patients and friends who are considering memorial gifts to direct those gifts and bequests to the State Medical Society Foundation. A physician can assure the potential donor that gifts may be earmarked for special purposes but that unspecified gifts will always be used for worthy educational, charitable, or research purposes in the medical field.

The Foundation is governed by a board of trustees composed of the members of the Council of the State Medical Society and an elected representative from each component county medical society.

THE MEDICAL FORUM

MEDICAL STUDENT LOAN FUND GETS FIRST BEQUEST

CLAMP DOWN ON SALE OF THREE REDUCING DRUGS

MILWAUKEE—The Better Business Bureau of Milwaukee recently released news service bulletins to Wisconsin newspapers, referring to sale of reducing drugs, as follows:

Fisk Research Inc., New York, after being served with a Post Office department fraud complaint, agreed to modify advertising claims for its reducing preparation, N.D.—17.

HUNGREX, TOO

A similar agreement was entered into by the Alleghany Pharmacal Corp., New York, for its Hungrex reducing preparation.

The Wonder Drug Co., New York, told the Post Office department it would terminate mail order sale of Regimen tablets.

KENOSHA CHIRO SUIT CONTINUES

KENOSHA—A decision in the third round of a test case involving the legal practice of chiropractic is expected in early spring.

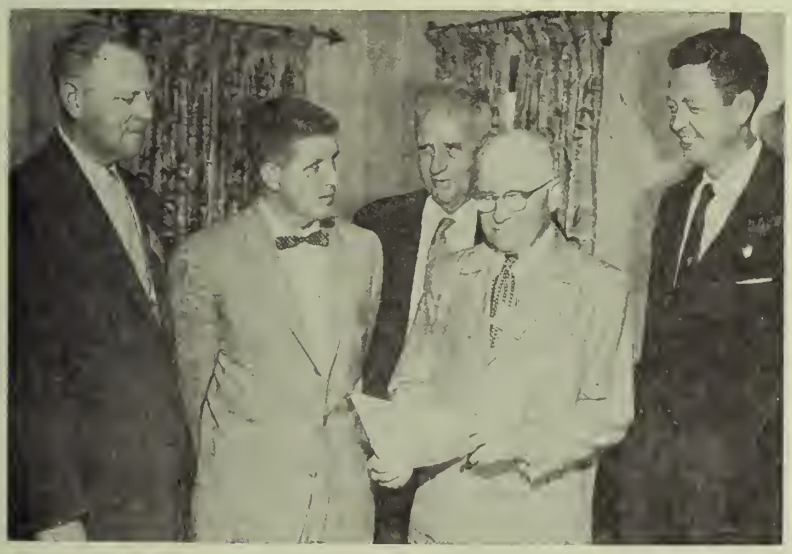
A hearing, which began in December, concerned an action started by Atty. Gen. Stewart G. Honeck to restrain R. L. Grayson, a Kenosha chiropractor, from using certain methods of treatment.

At issue is the limit of how far chiropractors can go in treating the sick. The state contends the chiropractors can do nothing beyond hand adjustment of the spinal column.

ISSUE CHALLENGED

According to the *Kenosha Evening News*, Atty. Robert Johns, La Crosse, counsel for Grayson,

(Continued on page 82)



TWO RIVERS—Participants in a circuit program for Wisconsin physicians here recently were (left to right): Dr. M. C. F. Lindert, assistant clinical professor of medicine, Marquette University, Milwaukee; Dr. George Collentine, Jr., assistant clinical professor of surgery, Marquette University; Dr. Alvah L. Newcomb, Chicago, associate professor of pediatrics, Northwestern University; Dr. A. H. Heidner, West Bend, session chairman, and Dr. John W. R. Thoma, assistant clinical professor of obstetrics and gynecology, Marquette University. Coming under discussion were such subjects as danger signals in obstetrics, massive intestinal hemorrhage and infants of diabetic mothers. The same team held sessions in Wausau and Delavan as part of an 18-part series which concluded with programs in Madison Jan. 21, Appleton Jan. 22, and Sheboygan Jan. 23.—*(Two Rivers Reporter photo)*

Mrs. Jackson Wills Sum to Honor Husband

MADISON—The Student Loan Fund of the State Medical Society's Charitable, Educational and Scientific Foundation has been named as one of the beneficiaries of the estate of Mrs. Reginald H. Jackson, who died Dec. 1.

Mrs. Jackson was the widow of Dr. Jackson, one of the founders of the Jackson Clinic in Madison. Dr. Jackson died in 1939.

Based upon a formula in her will, the Student Loan Fund will receive from $5,000 to $10,000. This is the first bequest to the society's Foundation, which administers the medical student loan fund.

In her will, Mrs. Jackson asked that the money be set up in a trust fund to be named in honor of her late husband and used for loans for medical students within Wisconsin.

GREAT NEED

Since 1951, when the student loan fund program was established, $41,510 has been loaned to 50 medical students. No interest is assessed until the students are licensed after internship.

Contributions to support the fund are made annually by society members on a voluntary basis.

Donations to this account also have been received from other interested sources. Those in direction of the loans estimate that the account will not achieve its purpose until there is more than $250,000 available.

The Foundation assumed direction of the fund project in 1955.

IN THE WORKS . . .

Every argument which has ever been used to support social security can be used with equal validity to support socialized medicine by changing a few words. If you ask for the one, prepare to get both. It is planned that way.

BRAVES ARE FINE PATIENTS, TEAM DOCTORS REPORT

Team Overcame Dozens of Injuries To Become 1957 World Champion

MILWAUKEE — They weren't cut in on any of the world series' booty, but the Braves' team physicians, Drs. Irwin Schulz and Bruce J. Brewer, certainly deserved such reward.

Medicine played a bigger role than usual in 1957. Injuries were so frequent that as the season rolled along, Mgr. Fred Haney had to find replacements for every one of his regulars at one time or another. He even had to find substitutes for his substitutes.

Dr. Schulz, a surgeon, acts as medical advisor to the baseball club. Dr. Brewer, an orthopedic surgeon, also treated the players on occasion.

It is a fact that half a cubic centimeter of hydrocortisone acetate and some novacaine may have been decisive in the series' conquest over the New York Yankees. The injections helped the "pitcher's elbow" of Lew Burdette, the fidgety, flighty right hander who won three games in the post-season showdown.

Burdette's elbow began bothering him in late May, and he went to Dr. Brewer June 3. An x-ray showed an area of calcification along the common flexor tendon at the joint. The physician flushed out the bursa sac with novacaine and injected hydrocortisone. In less than two weeks, big Lew was hurling again, and his arm caused no trouble the remainder of the campaign—except to opposing batters.

Haney himself spent five days in the hospital, with a gastroenteritis resulting from extreme fatigue in midseason. Even the coaches were unable to evade the injury plague. Connie Ryan pulled a leg muscle running up the dugout steps, and Johnny Riddle was out for a while with laryngitis.

Dr. Schulz

Among the ailments and injuries afflicting the Milwaukee club were a fractured fibula (Joe Adcock, first baseman); Asian flu (Eddie Mathews, third baseman; Warren Spahn, pitcher): wrenched knee (infielder Felix Mantilla); ankle sprain (outfielder Henry Aaron); eye infection (first baseman Frank Torre) and staphylococcus infection on the shin (shortstop Johnny Logan).

There also were torn ligaments, a chip fracture, sprained wrist, bruised elbow, strained and wrenched backs, assorted painful and swollen elbow joints and even a penicillin reaction.

Leading the injury parade was Adcock, who strained knee ligaments May 26. He missed 10 games and others at intervals later. Then he suffered a fractured fibula in a slide and was out of action until mid-September.

BRUTON BENCHED

A collision between Billy Bruton, center fielder, and Mantilla, both chasing a pop-up, seemed to be a disaster at the time, July 11. Bruton was benched for the rest of the campaign. Dr. Brewer aspirated bloody fluid from Mantilla's knee and he was back in action in a few weeks.

With Bruton out, it was necessary to find a replacement from a farm club. The choice was Bob Talbott of Wichita. It turned out, however, that Talbott was recuperating in Milwaukee Hospital himself, in a bed next to Bruton's. Talbott's knee had been operated on for removal of loose cartilage. The M.D. was Dr. Brewer. As a result, Bob Hazle, of Wichita, got his chance, and he made good in a big way, hitting over .500 the last third of the season.

Dr. Brewer

Orthopedists have no magic formula to restore injured baseball players to normalcy, Dr. Brewer said. Ultrasound, hydrocortisone injections and the more conservative measures all are used. One reason, he said, why they recover quicker than most folks is that they seek treatment earlier.

Drs. Schulz and Brewer agreed that baseball players make extraordinary patients. They are like high school athletes in their eagerness to stay in the game although injured or ill. They also try to keep an injury secret from the manager if they can.

Bob Buhl, for instance, pitched for two weeks with an elbow so painful he packed it in ice before each game and took pain relieving drugs. He finally gave in and went to the doctors. Ultrasound and cortisone were effective agents.

FIGHTING SPIRIT

Once under treatment, the Braves are excellent patients, the doctors reported. They are young, full of zest and in fine condition. They know that if they follow medical instructions closely they will get back into action sooner.

"The problem is to hold them back," Dr. Schulz said. "There's no goldbricking."

Competition for positions is intense. A player who gets out of shape is not around long. Some of the Braves do not even drink beer, Dr. Schulz said.

Neither physician can take time from practice to attend all games in Milwaukee, but contrive to see a

(Continued on page 82)

Division on School Health Proposes State Institute on Athletic Injuries

FOND DU LAC — Preliminary plans for a 1958 athletic injuries institute for physicians and coaches were discussed by the Division on School Health at its recent meeting.

No date or location for the institute was selected. It is expected to generate much interest in improved means to prevent and treat injuries incurred in sports competition.

Initial planning stressed a one-day program, in cooperation with the Wisconsin Interscholastic Athletic Association (WIAA), the State Board of Health, State Department of Public Instruction and other groups. Such topics as neurology; contusions, lacerations, inflammations, knee and ankle; growth development and fatigue, taping and physiotherapy would be included.

It was decided to have a planning committee survey necessary steps for development of a program.

The division also recommended that county medical societies be urged to appoint school health chairmen or committees to arrange local school health conferences or meetings with school officials on pertinent health matters affecting pupils.

In other action, the division:

Asked for more emphasis on the State Medical Society's iodized salt tablet program for school children. This calls for dispensing the tablets in both grade and high schools to fight against goiter.

Recommended showings of the exhibit, "Health Appraisal of the School Child," which includes slides pertaining to health examinations. The slides were prepared by Dr. E. H. Pawsat, Fond du Lac, former division chairman. Plans call for the exhibit to be scheduled for the society's annual meeting in Milwaukee May 6–8 and the state teachers' convention in Milwaukee next November.

The division's subcommittee advisory to the W.I.A.A. recommended that high school athletes with back and disc injuries be withheld from football play for a one-year period after the injury occurs, and that Mr. John E. Roberts, Marinette, W.I.A.A. executive secretary, continue studies and tests to improve football equipment, including helmets and shoes, to further reduce injuries.

Use of helmets with protective bars during the past two grid seasons, Mr. Roberts said, had reduced head injuries. As a result, the W.I.A.A. Board of Control voted to require all teams to wear them in Wisconsin in 1958.

DISCUSS MEDICO-LEGAL PROBLEMS

MADISON—More than 125 physicians and lawyers turned out for a recent meeting devoted to solving common medico-legal problems.

The Dane County Medical Society and the Dane County Bar Association held a panel on various phases of the Interprofessional Code, a guide for cooperation developed by the State Medical Society and the Wisconsin Bar Association several years ago, following extensive study.

The physician must make it clear to the attorney that medicine is seldom an exact science. The element of risk and complication is present in almost any treatment or procedure.

Medical evidence to be presented in court should be prepared carefully, factually and be based on simple fundamentals. Testimony is given in technical language first, and then re-stated in laymen's language. In both cases, it must be presented with honesty, accuracy and clarity.

Always ask for a broad release in writing from a patient before giving medical information to others. Be on guard against the patient who decides to rescind permission to release such information.

Always hold a pre-trial conference of attorney and physician outside the courtroom. The physician-witness should sit in the audience until called to the stand.

The physician must educate the attorney on technical phases of his testimony, before the trial. The physician must not be pretentious or too positive, and should acknowledge limitations.

Participating in the panel were Drs. T. J. Nereim, Eugene J. Nordby and Henry M. Suckle, and Attys. Robert B. L. Murphy, Edwin Conrad and Edwin C. Pick, all of Madison.

Mental Health Report Available

NEW YORK—Availability of "Steps for Today Toward Better Mental Health," the report of the 1957 National Health Forum, was announced this month by the National Health Council.

The report is a digest of contributions made by 102 program participants in the course of 15 discussions and eight general sessions. It ranges from analysis of the impact of mental illness to specific examinations of in-service training programs.

Copies may be obtained at $1.50 each from the Council office, 1790 Broadway, New York City 19, N. Y.

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MILWAUKEE WISCONSIN

NEW COUNCIL NOW SCREENING FOREIGN MEDICAL GRADUATES

EVANSTON, ILL.—The medical profession's answer to the mushrooming problem posed by the thousands of foreign-trained physicians in this country began operations late last fall.

After three years of planning, the Educational Council for Foreign Medical graduates opened its doors here. It will carry out a detailed and comprehensive program for evaluating foreign medical school graduates. It also will distribute information everywhere regarding the opportunities and difficulties involved in coming here on an exchange student visa to take intern or resident training in a U.S. hospital, or coming on an immigrant visa with the hope of becoming licensed to practice.

A three-way screening process will include:

1. The council will certify a student's educational credentials and note if certain minimal standards have been met, I.E., 18 years of formal education, including four years in a bona fide medical school, but excluding hospital training.
2. The council will certify that an applicants' command of English has been tested and found adequate for assuming internship in an American hospital.
3. The council will certify that the general knowledge of medicine, as evidenced by the passing of the American Medical Qualification Examination, is adequate for assuming such an internship.

Hospitals, state licensing boards and specialty boards will be informed of the results of the screening procedure. The council plans to accumulate and publish annually complete data regarding the numbers and placement of foreign medical graduates in this country.

Dr. Dean F. Smiley, Chicago, former secretary of the Association of American Medical Colleges, will be executive director of the council.

He said the council would not serve as a placement agency, would not attempt to evaluate the teaching program, inspect or approve any foreign medical school, and was not formulated to act as an intercessor for the graduates having problems with state boards of medical licensure or specialty boards.

Plans call for the first examination of foreign applicants in late February or March, 1958, with the second expected to be held in July or August.

Dr. J. Murray Kinsman, president of the council's board of trustees, said the screening process was initiated to help maintain the present high medical standards in the U.S. by making sure that foreign-trained physicians wishing to come here have a level of educational attainment comparable to that of students in approved American medical schools at the time of graduation.

"At the same time," he added, "the council hopes to encourage the well-trained foreign physician to take advantage of the opportunities to further his education in this country."

Presently, there are 6,000 foreign-trained physicians in the U.S. on temporary visas serving as interns or residents. Those on such visas are expected to return to their native countries on completion of their training here. Another 1,000 enter this country each year as immigrants or as American citizens returning after completing their medical education abroad.

OK FOUR NEW HOSPITAL PROJECTS

WASHINGTON—Approval of four hospital projects in Wisconsin has been announced by the U. S. Department of Health, Education and Welfare.

The projects, with amount of federal aid in parenthesis:

West Allis Memorial, $5,000,000 ($500,000), 250 beds; Park Falls Hospital, $327,000 ($130,000), 35 beds; Fort Atkinson Memorial, $487,045 ($188,760), 30 beds and Platteville Municipal, $210,300 ($63,436), 22 beds.

The department reported that 11 other projects had been completed in 1957, costing $11,870,645 ($3,191,396) and supplying 490 additional beds.

Presently under construction are 24 projects, to cost $15,596,575 ($5,958,187) to supply 495 more beds. Approved but not under construction are 47 projects to cost $38,180,715 ($12,354,076) to bring 1,995 new beds to Wisconsin hospitals.

All of the projects are covered under Hill-Burton grants.

SMS Plans Strict Adherence to NAIC Advertising Code

MADISON—The State Medical Society's Commission on Medical Care Plans has notified the Wisconsin Insurance Commission of its willingness to conform voluntarily with the National Association of Insurance Commissioners' advertising code in the field of sickness and accident insurance.

All advertising will as in the past, be prepared in strict accordance with the N. A. I. C. code. This means that descriptive material relating to Blue Shield of Wisconsin surgical-medical programs will clearly identify the policy referred to, and that extreme care will be used to present exclusions as well as benefits. Every attempt will be made to present details of the programs to avoid misrepresentation and to avoid misleading the readers.

The code also covers such matters as disparaging comparisons and statements; vague descriptions of service facilities; excessive and deceptive wordage, phrases or illustrations; limitations, testimonials and endorsements, use of statistics and the like.

Wisconsin Physicians Service has made every effort in the past to conduct its advertising programs on a high scale, such as outlined by the code.

THE PHYSICIAN

He never knows which hours are his own
To spend with his small children, or his wife.
A slave is he unto the telephone
That summons him to battle death for life.
There's no appeal that's ever turned away,
Though weary he may be; to those in need
His services are pledged by night or day,
And he will never fail to live his creed.
His cheery manner is soothing balm;
By his sincere and heartful sympathy
He lessens fear, and fosters quiet calm!
May all physicians, Lord, be blest by Thee!

—Corinne Hughes

TOPS, Born in Wisconsin, Depends On M.D. Guidance and Counsel

MILWAUKEE—TOPS was born in a doctor's office, held its first convention in A. M. A. headquarters in Chicago, and now regards physicians as No. 1 contributors to its success.

In 1948, Mrs. Esther S. Manz discussed with Dr. C. F. McDonald, Milwaukee, the possibility of starting a club based on the idea of group therapy for the obese. The two agreed that the desire to lose weight could be encouraged into the will to lose it by the simple psychology of competitive play.

Mrs. Manz established her first club at a Milwaukee recreation center. From the success of that first group, TOPS (Take Off Pounds Sensibly) has grown to a national institution, with more than 15,000 members. About 3,000 of these are in Wisconsin.

The first national convention was held at the A. M. A. in 1953. Dr. W. W. Bauer, director of the A. M. A. Bureau of Health Education, said:

"Through such close contact, it has been possible to evaluate the organization's program thoroughly. It is considered an acceptable weight reduction project that commends itself to the medical profession and to those who are sincerely interested in solving what has been described as one of the most pressing problems of our generation.

"TOPS espouses two basic principles—that weight reduction can be carried out most satisfactorily through consultation with one's physician, and that 'fads' and 'diets' have no place in any such program."

Dr. Bauer said Mrs. Manz and other TOPS officers have resisted tremendous commercial pressures "that would have reduced the organization to nothing more than a vehicle for promotion of various special diets or food preparations."

Dr. McDonald has conducted OB classes for over 30 years. Commenting on the origin of TOPS, he said:

"In my classes, I have the women vie with each other to keep their weights. Mrs. Manz, a social-minded lady, was struck with the way the ladies did keep their weights in little competitive races. So she thought she would devise a club. She came in to get my diets. I advised her that if she wanted to enter into this sort of thing she should use nobody's diet—but her own doctor's, of course—and that she should have each club member come to the meetings prepared with directives and diets from her own doctor.

"She accepted this advice and TOPS has grown remarkably. The group has no medical officers or members of TOPS as such."

TOPS is not a course of a few weeks or months. It is a planned, continuing program dedicated to helping the overweight. The A. M. A. only in unusual situations attempts to give official status to lay groups. Evidence of its acceptability was the turning over of rooms to TOPS for the national meeting.

Mrs. Manz explains that TOPS "is not a traveling medicine show offering overnight miracle cures through the magic of newly-discovered pills, potions or creams 'absolutely guaranteed' to make the purchaser lose weight.

"We say, see your doctor, have him outline a weight reducing program for *you*, and then work together with others in the same boat to shed pounds. We say, chins up, and be of good cheer."

TOPS is a non-profit organization incorporated under the laws of Wisconsin. Officers and a board of directors are administrators, but the heart of the movement, Mrs. Manz tells you, is the membership. . . the 800 local clubs granted charters in all parts of the continent.

Mrs. Manz

The local clubs have names like these:

Good Losers, Dieteers, B-Liters, Shrinking Violets, Lo-Cal Gals, Snack Snubbers, Blubber Busters, Waist-Away, Trimmin' Women, Slender Benders, Scale Scanners, Inches Anonymous, Hips Away and Melting Pots.

Recognition is given to those showing the best adherence to suggestions relative to losing weight, and a national queen and princess are selected at annual gatherings.

Recently the club was expanded to include teen-agers, men and "tiny tops." Already there are male groups in Wisconsin, Ohio, Iowa, Michigan and Massachusetts.

Officers are quick to give praise to physicians, and often call on them to speak at group meetings. Current health problems, as well as the dangers of obesity, are discussed.

"It's organized will power, sugar-coated with fun and relaxation, and packaged in mutual understanding and common sense," Mrs. Manz says.

WANT INFORMATION

Doctors and others desiring information about TOPS or allied organizations can obtain it by writing to Mrs. Esther S. Manz, national president of TOPS Club Inc., 2306 South Howell avenue, Milwaukee 7. Inquiries are welcomed.

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NAUTICAL MINDED WISCONSIN MD'S BOOST SAFETY

MADISON—State Medical Society first aid posters logged hundreds of miles on Wisconsin and Illinois waters last summer.

Acting on a suggestion of Dr. David N. Goldstein, of Kenosha, the U. S. Power Squadron, Chicago district, reproduced the charts in smaller size and urged members to place them on medicine cabinets on each boat. Each chart carries the words "prepared by the State Medical Society of Wisconsin."

Dr. Goldstein

Other squadrons are being urged to do likewise, as a safety measure.

The U. S. Power Squadrons have over 35,000 active members in the country at the present time. They are divided into 25 districts and 223 local squadrons. The Kenosha Power Squadron is in District 20.

District 10 includes Appleton, Fond du Lac, Green Bay, Marinette, Milwaukee, Oshkosh, Sheboygan and Sturgeon Bay. Commander of this group is Dr. Arthur W. Hankwitz, Milwaukee.

Dr. Richard M. Block is an instructor at Kenosha, and Dr. Goldstein is chairman of the safety commission.

The organization is primarily an educational body, devoted to promotion of safety in boating. Requirements for membership include citizenship and successful completion of a basic course in piloting. Progressively more difficult courses are presented, under the titles of seamanship, advanced piloting, junior navigation and navigation.

The squadrons have no official governmental status, but are always included in U.S. Navy and Coast Guard deliberations referable to navigation and boating. The U.S.P.S. compiled an excellent record in recent wars, particularly in the field of instruction.

R. N. Chatain Jr., secretary of the Chicago squadron, recently informed Dr. Goldstein that initial response to the charts was most encouraging.

MISSIONARY WORK FIELD OF TWO S.M.S. MEMBERS

MADISON—Two members of the State Medical Society of Wisconsin are serving as medical missionaries.

Dr. Lonnie C. Grant, stationed at the Sudan Interior Mission, Jos, N. Nigeria, West Africa, is a specialist in internal medicine. He served as a resident at the VA hospital, Wood, Wis., and as a teaching assistant at the Marquette University School of Medicine from 1946 through 1949.

A diplomate of the National Board of Medical Examiners, he has been out of the United States since 1950.

A surgeon, Dr. Donald P. Davis, is at Memorial Hospital, Fatehgarh, U.P., India. He was graduated from Marquette University and was in residency at Columbia Hospital, Milwaukee Muirdale Sanatorium, Wauwatosa and the VA hospital in Wood.

AT THE CONTROLS of his cruiser is Dr. Arthur W. Hankwitz, Milwaukee, commander of U. S. Power Squadron District No. 10. His interest in things nautical include free boat-handling instructions for all interested persons at 10 classes last fall. Similar courses were offered without cost in Sheboygan, Fond du Lac, Green Bay, Oshkosh, Appleton, Sturgeon Bay, Marinette and Duluth, and included safety afloat, seamanship, mariner's compass, aids to navigation, equipment, government regulations, rules of the nautical road, charts and piloting, and manners and customs on shipboard.

Drs. Clark H. Boren, James A. Boren and C. H. Boren, Marinette, are active members of the Menominee–Marinette power squadron.

Other physicians in Dr. Hankwitz's district include Drs. George O. Dunker, Glen Stockdyk, Frank Darling and Sylvester Darling, Milwaukee; Edwin H. Everts, Hales Corners, and Hubert D. Grota of Sturgeon Bay.

Start Statewide Cytology Program

MADISON—A county unit cytology program, backed by local medical societies in all sections of Wisconsin, has been started by the Wisconsin Division, American Cancer Society.

The division said that without proper medical approval and cooperation the public education effort would not be possible or successful. Programs now in progress elsewhere, it added, indicate that success may be insured, first by getting local physicians behind it before stimulating public interest, and second, by continuing to work through physicians.

The program calls for establishment of laboratory facilities and recruiting and training cytotechnologists in areas where needed, the examinations for uterine cancer, and then providing continuity of follow-up examinations.

The general public will be informed of the value of the examination through radio announcements, newspaper articles, programs before local organizations and regarded as most important, showing of the film, **"Time and Two Women."**

The film, which is shown only with an M.D. or R.N. in attendance to answer questions, deals with a serious subject with clarity and good taste. Its purpose is to explain how cancer of the uterus may eventually be eliminated as a cause of death, and that time may be a woman's ally or enemy in this illness. A story is told of two women, each faced with cancer.

OFFER FILM ON HYPOTHYROIDISM

MORRIS PLAINS, N. J.—Availability of a new 30-minute color film, "Hypothyroidism," was announced by Warner-Chilcott Laboratories this month.

Loaned without charge, the film covers the full range of thyroid dysfunction, from frank myxedema to subclinical hypothyroidism. Physiology, diagnosis and therapy are discussed and illustrated. Emphasis is placed on current concepts in diagnostic problems and methods.

Screenings may be arranged through the laboratories, or the State Medical Society of Wisconsin, Box 1109, Madison 1.

Urge Physicians to Learn More Of Wisconsin Blind Services

MADISON — Doctor, are you fully acquainted with the services to blind persons in Wisconsin?

A booklet, "Services to the Blind in Wisconsin," has been prepared by the Services to the Blind, Division of Public Assistance, State Department of Public Welfare. It is available without cost from the services' Madison office, 207 N. Pinckney street; from its main office at 2385 N. Lake Drive in Milwaukee; or from district offices in Green Bay, Ashland and Eau Claire. It is also available through the State Medical Society, Box 1109, Madison.

One of every 20 referrals to the state agency is made by a physician. The others are made through public welfare agencies, which accounts for 33 per cent; interested individuals other than physicians; from schools for the handicapped; self-referral, and allied agencies.

Services to the Blind is a program financed by funds from the state and federal treasuries and includes all state services available to the adult blind in Wisconsin with the exception of direct financial grants to the blind (administered by counties) and the Summer School for the Adult Blind (administered by the State Department of Public Instruction).

The program is designed to provide a blind person with the help he needs from the time he first needs it until he has achieved and is exercising his maximum abilities.

Services are divided into five areas: social services, rehabilitation, business enterprises, sheltered employment and home industries.

Rehabilitation is designed to minimize an employment handicap caused by loss of sight and to place a blind person in suitable remunerative employment. Diagnostic services including medical examinations and psychological testing; medical, surgical, hospital and psychiatric assistance; occupational and physical therapy; artificial appliances; educational and occupational training and attendant supplies, maintenance and travel; occupational tools and equipment for use in a trade or business; placement in employment, counselling and guidance are included.

There are 3,885 blind persons in Wisconsin. Of these, 845 are employed, 241 as homemakers, 107 in skilled, professional fields, 275 semi-skilled and the remainder in unskilled occupations.

The booklet discloses that cataract is the most serious offender, resulting in more than 20 per cent of the cases of blindness. Next is optic nerve atrophy, and then follows glaucoma and diseases of the retina. A blind person is described as a person with 20/200 visual acuity or less.

Statistical tables showing the number of registered blind per 10,000 population in Wisconsin counties; the number of blind by age; racial distribution; extent of visual loss; age on onset of blindness; causes of blindness, by topography, and by etiology; sources of referral, and present occupations of blind persons are included in the 24-page booklet.

Wisconsin M. D. Initiates Plan For New Exhibit

CLEVELAND, OHIO — An exhibit created in response to a proposal by a Wisconsin doctor was awarded a certificate of merit at the recent American Public Health Association convention.

Some months ago, Dr. E. H. Pawsat, Fond du Lac, Wis., prepared a series of color slides on medical examination of school children. It was his thought that the slides could be part of a display on all-over health of the children. The A. M. A. bureaus of health education and exhibits agreed, and designed other panels showing teacher observation, screening procedures and dental examinations.

The exhibit is of interest to physicians, educators, parents and others. It will be shown at the 117th annual meeting of the State Medical Society of Wisconsin in Milwaukee next May, and is also available to county medical societies without cost. Inquiries should be directed to the A. M. A. or the State Medical Society of Wisconsin, Box 1109, Madison 1.

Dr. Pawsat is a former chairman of the society's Division on School Health.

Mental Care for Children Badly Needed—Schmidt

MADISON—Hundreds of mentally retarded children do not have adequate treatment, Wilbur J. Schmidt, director of the State Department of Public Welfare, said in a public statement recently.

"The number of children suffering from mental illness is increasing," he said. "This trend is resulting in hundreds of wasted lives in addition to costly years of care and treatment in our mental hospitals.

"There is no institutional treatment facility, public or voluntary, in Wisconsin for the treatment of these children. Now the youngsters are kept at home, in foster homes, or in adult mental hospitals. This produces acute problems and does not help the children.

"The Wisconsin Child Center is not geared to serve all the needs of these disturbed boys and girls."

Milwaukee County alone, Schmidt said, has 645 children with severe emotional problems, and 541 are not receiving proper treatment.

The 1957 legislature turned down the department's request for a residential treatment center for 50 children over five years of age.

"The children need protected living situations, casework and psychiatric treatment, remedial education and group work," Schmidt declared. "Those with severe emotional problems cannot be treated adequately in our present institutions."

The director said care of such children is quite costly, averaging $8,000—$10,000 a year. The proposed center was estimated to cost the state $500,000 annually to operate.

"There will be continuing efforts to see that the necessary treatment is provided for these children who are now deprived of it," he added.

Hidden Levy . . .

SOCIAL SECURITY SAYS: "People are taxed only once for Social Security."

In Other Words: The employer who must pay his share of the social security tax for each of his employees increases the price of his product or service to cover this additional cost of doing business. Everybody pays this increase as a hidden "sales tax."

KENOSHA CHIRO . . .

(Continued from page 75)

contends that the limits are much wider and include "clinical nutrition, psychotherapy and physiotherapy."

Johns challenged the court's earlier decision on the definition to be used in the actual trial of the issues. He said the court had erred, and claimed the legislature intended the field of chiropractic to be broader than the adjustment by hand only.

The case, of statewide interest, began in January, 1957. Judge M. Eugene Baker is hearing arguments currently, and will rule on the test suit.

Foes of Fluoridation Assailed in Pamphlet

NEW YORK—Suspicious people whose counterparts once opposed vaccination and pasteurization now are depriving millions of children of the advantages of fluoridation, Dr. Louis I. Dublin, consultant to the Institute of Life Insurance, said.

His statement is included in a 25-page pamphlet, "Water Fluoridation: Facts, not Myths," published by the Public Affairs Committee.

"Once citizens make it their business to learn the facts, opposition to water fluoridation will disappear like a bad dream," Dr. Dublin said.

Next to the common cold, tooth decay is probably the most universal disease suffered by mankind, and tremendous savings can be effected through fluoridation, he contended, adding:

"Opponents use arguments which combine politics, prejudice and pseudo-science. Some go so far as to claim that fluoridation is a Communist conspiracy to soften our brains and make mass sabotage possible.

"A number of critics have persuaded themselves that they are fighting some kind of sinister conspiracy, despite widespread confirmation and support from scientists and major professional organizations."

The pamphlet may be secured from the Public Affairs Committee, 22 East 38th street, New York City 16, for 25 cents a copy. Lower rates for bulk orders.

On the S.M.S. Calendar

January
- 30–31—Wisconsin Council of Safety, Milwaukee

February
- 3–5—National Blue Shield Professional Relations Conference, Chicago
- 5—Claims Committee, S.M.S.
- 9–11—A.M.A. Congress on Medical Education and Licensure, Chicago
- 15—2nd Annual Wisconsin Doctors' Bowling Tournament, Fond du Lac
- 28—Annual Meeting, General Council, S.M.S.

March
- 1–2—Annual Meeting, General Council, S.M.S.
- 5—Claims Committee, S.M.S.
- 6–8—A.M.A. Rural Health Conference, Jackson, Miss.

May 6–8—Annual Meeting, State Medical Society, Milwaukee!

TV SERIES SHOWN IN SIX CITIES

MADISON—During the past two years, the State Medical Society's March of Medicine television series has reached every city with a TV station in the state except Milwaukee.

First to show the 13-part half hour program was WHA–TV, Madison. Then followed WBAY–TV in Green Bay; WMTV, Madison; WSAU–TV, Wausau; WEAU–TV, Eau Claire; WMBV–TV, Marinette, and presently, WKBT in La Crosse.

Every showing was made with the cooperation of the local county medical society, as co-sponsor.

The series features Dr. Robert C. Parkin, assistant to the dean of the University of Wisconsin Medical School, and other physicians, appearing on a guest basis. Subjects covered included allergy, heart disease, cancer, overweight, psychosomatic medicine, children's emotional problems, diabetes, arthritis, high blood pressure, anesthesia, headaches and the musculoskeletal system.

BRAVES . . .

(Continued from page 76)

fair share. The pleasant assignment of attending doctor at the games is passed around among members of the Milwaukee Hospital house staff.

Dr. Schulz began attending to problems of the care and repair of ball players with the old Milwaukee Brewers, who shifted to Wichita when the Braves moved to Milwaukee from Boston in 1953. The Braves sized him up, like him, and asked him to be their M.D.

"My job with the Braves," Dr. Schulz said, "Is to see they get the best possible medical care."

To achieve this, consultants are used liberally, i.e., a cardiologist and a gastroenterologist were called in to see Haney.

Dr. Schulz instituted a medical review of farm team problems to make sure minor league players are not handicapped for lack of followup of treatment. Already this policy has paid off.

Both doctors have learned that their relationship with the Braves has extended beyond official limits. Dr. Schulz has found general practitioners, obstetricians and pediatricians for players and their families. And Dr. Brewer sacrificed to first, so to speak. . .

First, in this instance, was Joe Adcock, first baseman, who had a sore shoulder. While the physician was treating it, Joe was smitten with Joan James, Dr. Brewer's medical assistant. Pretty soon Joe and Miss James were married, and Dr. Brewer was forced to hunt up a replacement.

"He recovered from the shoulder injury," the doctor commented drily, "but the other affliction seems to be more lasting."

CHARITY?

SOCIAL SECURITY SAYS: "A woman who becomes entitled to benefits based on her own earnings and also the wife's benefits on the earnings of her husband would receive no more than the larger of the two amounts. A child who becomes entitled to child's benefits based on earnings of both his father and mother would not receive both payments."

In Other Words: Double social security taxes paid by one family do not produce benefits for each member paying the taxes. A part of the taxes go to "charity."

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Volume 57 JANUARY 1958

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Guide to Evaluation of Permanent Impairment of Extremities and Back

The Physicians' Guide for the medical rating of physical impairment, recently completed by a special committee of the American Medical Association, is published in several January, 1958, issues of *The Journal of the American Medical Association.* This valuable publication not only will help solve problems in compensation and other insurance cases but also will assist in determining eligibility for benefits under the new social legislation written in the statute books a year ago by Congress.[1]

The material is condensed in 115 pages of text which include illustrations, tables, and testing procedures. It represents a thorough study of the opinions of recognized medical and other authorities concerned with the task of disability evaluation.

The superb job done by the committee with this difficult subject has won for them the deserved commendation of our representatives in the House of Delegates and will earn the gratitude of the many physicians who are confronted with patients under 65 years of age asking for social security benefits.

Disturbances of the extremities and back are covered in minute detail. In those instances where organic interference with function is present, this guide greatly simplifies the work of measuring the impairment, and expressing it in numerical terms.

Physicians called upon to evaluate complaints which have no demonstrable organic component and to estimate impaired function caused by diseases other than those of the musculoskeletal system will look forward to future publications of the committee.—R. S. BALDWIN, M. D.

[1] Hess, Arthur E.: Determining Disability Under Social Security, Wisconsin M. J. 56:37–42 (Jan.) 1957.

A Quick Look Inside Russia

Sputnik I and Sputnik II have so jolted everyone's interest in Russia that first-hand accounts of visits to that country have become almost prized possessions. Physicians will find a special interest in the impressions of A.M.A. president-elect, Dr. Gunnar Gundersen of La Crosse, who recently returned from 11 days in the U.S.S.R. in conjunction with a meeting of the World Medical Association.

Here are a few excerpts from Doctor Gundersen's report of his visit:

"Russia has a population of roughly 200,000,000. There are 360,000 physicians. Medical education is conducted in about 80 medical schools. They admit that production is satisfactory, but that the distribution is not satisfactory. For instance, in the medi-

cal school at Moscow there are 4,500 students in a six-year course so there are about 500 or 600 graduates annually. The course begins after preliminary education at the age of 18. Following completion of the course students graduate as physicians but not doctors of medicine. Ten per cent of the graduates go on into a three-year continuation course and 90 per cent go out as general practitioners in the various areas.

"We were told that the supply of physicians is adequate from these 80 schools, but the distribution is not satisfactory. Consequently, incentive pay for practicing in undesirable locations is necessary.

"Engineering seems to be the most preferred profession. The hospitals seem crowded. The beds were together and the wards contained up to 30 people. Two-bed and four-bed rooms were quite common in the neurological institute which we visited. The number of hospital beds per population was not obtained. It seemed that they were unwilling or unable to give us this information. . . The work being done seems to be of a high order by able men working under rather difficult and cramped conditions.

"One neurosurgeon was doing a nerve tumor and after the exposure got into troublesome bleeding requiring blood. Blood was not available or was not being given to cover the loss. Consequently, the procedure had to be stopped and he was to do the actual operation at a later session two weeks hence after the patient had recovered. He succeeded in ligating the lateral sinus and stopping the bleeding before the first procedure was started.

"Women have obtained complete equality with men and they can be seen working on construction jobs, as street sweepers, and in nearly every type of hard work. There seems to be much manufactured work in Russia, reminiscent of the W.P.A. days in this country.

"During our stay in Russia we did not see one car which we could identify as a privately owned one. They claim to be making 400,000 cars a year, most of which are trucks and which are most essential for the economy. The trolleys and busses seem excellent. In Moscow, as elsewhere in Russia, everyone looks exactly the same; that is drab. No decent clothes are worn. There is no evidence of prosperity. The hotels are old and poorly maintained. The elevators are of an old vintage, hand-operated. Busts and paintings of Stalin and Lenin are everywhere in evidence.

"The press is completely controlled by *Pravda* and *Izvestia* and people apparently are only allowed to read what the dictators want them to.

"Favorable impressions in Russia are certainly many, particularly the ballet and opera and their efforts to provide for children. Cleanliness on the streets is very good, but the markets where food and meats are sold are unspeakable.

"One is impressed with the bragging which takes place on the part of the Intourist guides over everything Russian. Everything is the biggest and the Russians made all the inventions, etc. The churches, which have been abolished and are now to a large extent religious museums only of historical interest, were open and seemed to be well attended. The shops are not impressive. They look for everything in the world like a bargain counter. They are crowded. The prices are high. An ordinary suit costs about $200 but nobody has the $200.

"We were told by people in the embassy service that they have no freedom of movement whatsoever. An iron curtain country it truly is; a police state without question.

"After having spent only 11 days in the 'Worker's Paradise' it would seem to me that folks who are interested in extension of the welfare state should go to Russia to see what the situation really is like. It is quite obvious that with the total welfare state, freedom ceases to exist. There is no question but what it tends to level everybody downward. It certainly fails to upgrade anything except that possibly it does spread whatever goods there are to a larger number of people. If this represents an improvement over what the conditions were before the revolution then one can only say that the conditions at that time must have been unspeakable."

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY EXAMINATIONS

The next scheduled examinations (Part II), oral and clinical, for all candidates will be conducted at the Edgewater Beach Hotel, Chicago, Illinois, by the entire Board from May 7 through 17, 1958. Formal notice of the exact time of each candidate's examination will be sent him in advance of the examination dates.

Candidates who participated in the Part I examinations will be notified of their eligibility for the Part II examinations as soon as possible.

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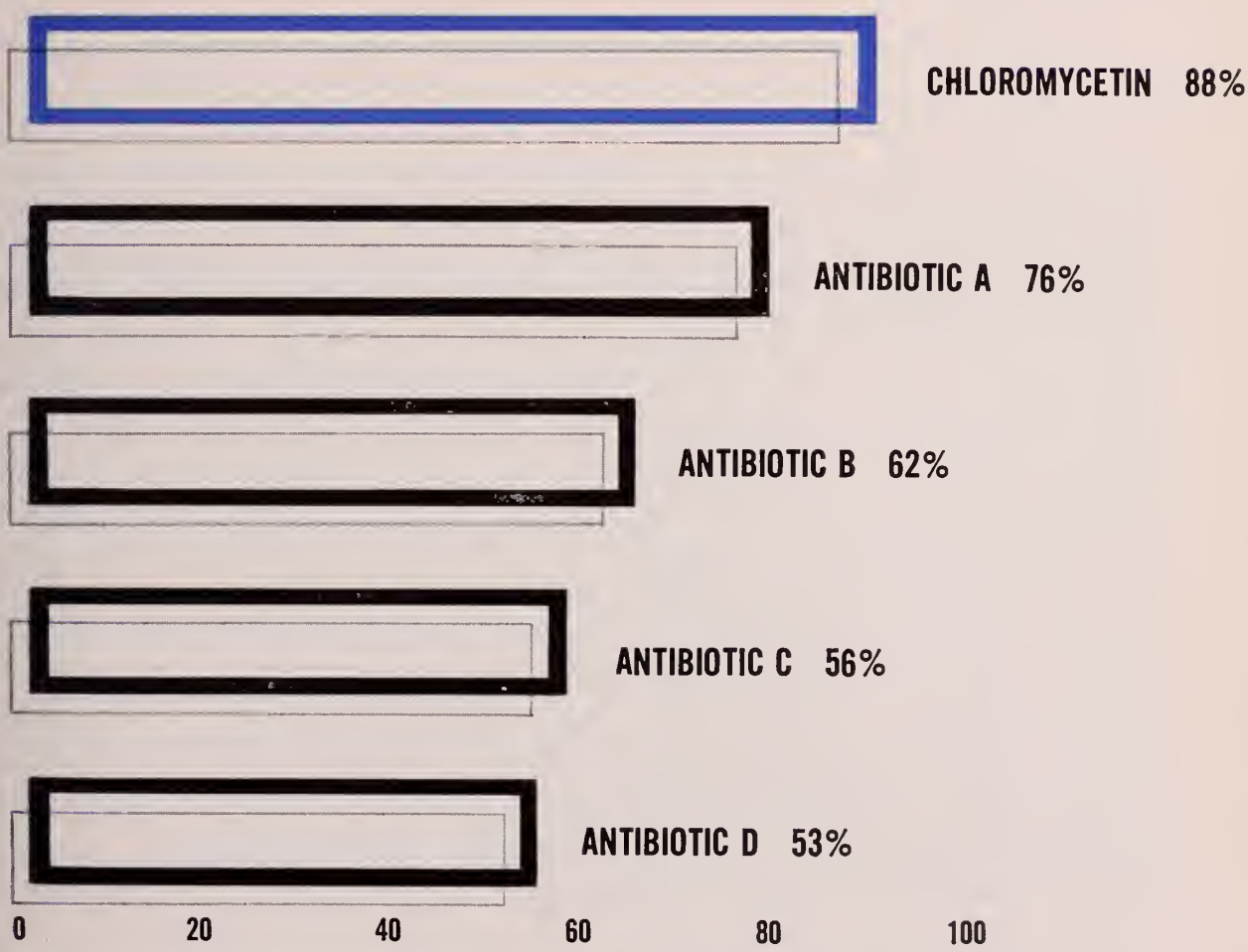

*Adapted from Ditmore and Lind.[2] Organisms tested were isolated from stools of 48 patients.

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for the Diagnosis, Care and Treatment of Nervous and Mental Disorders

ST. CROIXDALE ON LAKE ST. CROIX

PRESCOTT, WISCONSIN

Located on beautiful Lake St. Croix, 18 miles from the Twin Cities, it has the advantages of both City and Country. Every facility for treatment provided, including recreational activities and occupational therapy under trained personnel. Close personal supervision given patients, and modern methods of therapy employed. Inspection and cooperation by reputable physicians invited. Rates very reasonable. Illustrated folder on request.

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Consulting Neuro-Psychiatrists
Hewitt B. Hannah, M.D. : Andrew J. Leemhuis, M.D.
511 Medical Arts Bldg., Tel. MAin 1357, Minneapolis, Minn.

Superintendent
Ella M. Leseman
Prescott, Wisconsin
Tel. 69

* 1. Clyman, S. G.: Postgrad. Med. *21*:309, 1957.
2. Bleiberg, J.: J. M. Soc. New Jersey *53*:37, 1956.
3. Abrams, B. P., and Shaw, C.: Clin. Med. *3*:839, 1956.
4. Welsh, A. L., and Ede, M.: Ohio State M. J. *50*:837, 1954.
5. Bleiberg, J.: Am. Practitioner *8*:1404, 1957.

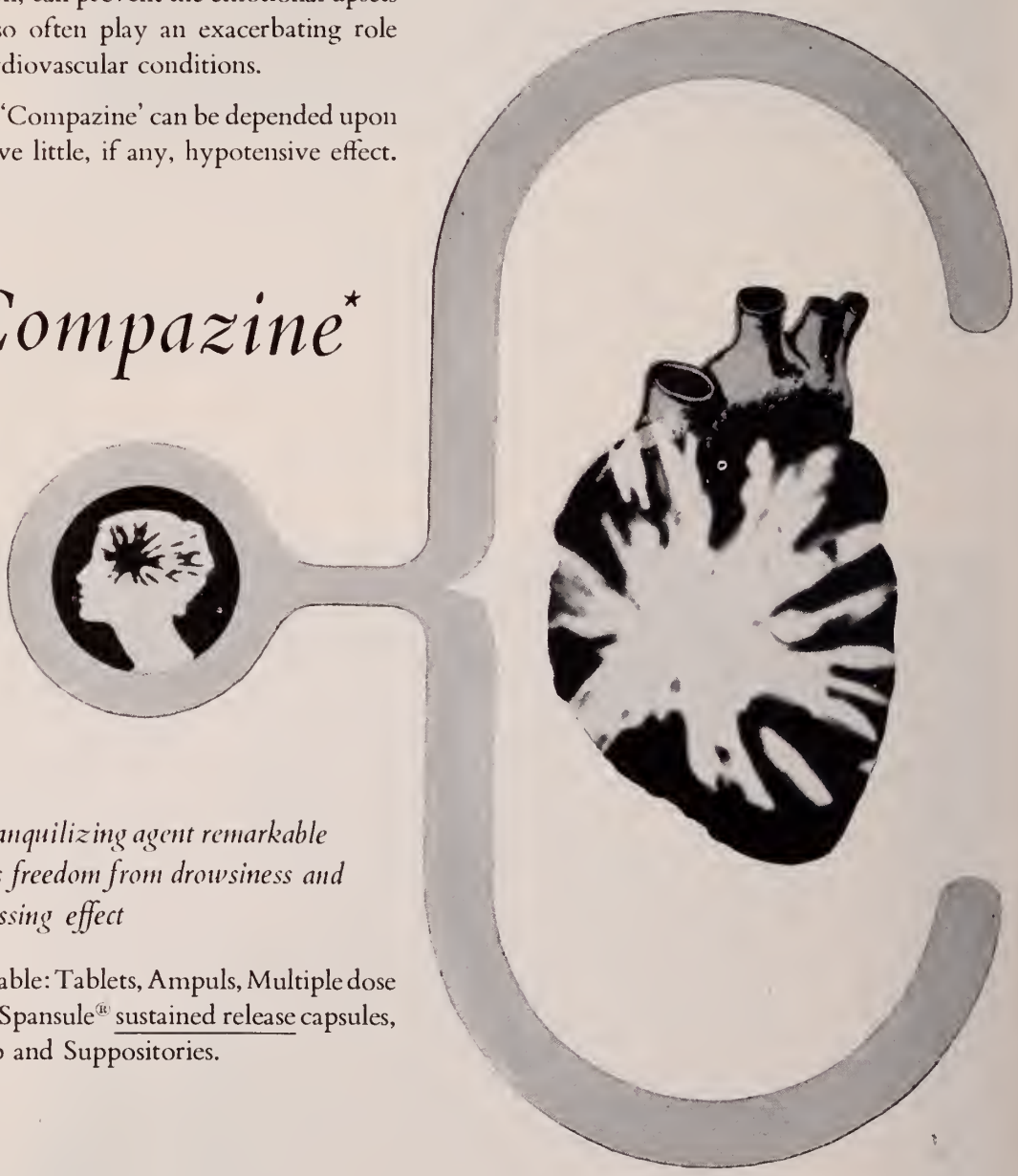
R&C REED & CARNRICK / Jersey City 6, New Jersey

To prevent emotional upsets in cardiovascular conditions

'Compazine', by controlling anxiety and tension, can prevent the emotional upsets that so often play an exacerbating role in cardiovascular conditions.

And, 'Compazine' can be depended upon to have little, if any, hypotensive effect.

*Compazine**



the tranquilizing agent remarkable for its freedom from drowsiness and depressing effect

Available: Tablets, Ampuls, Multiple dose vials, Spansule® sustained release capsules, Syrup and Suppositories.

Smith Kline & French Laboratories, Philadelphia

★T.M. Reg. U.S. Pat. Off. for prochlorperazine, S.K.F.

for "This Wormy World"

Pleasant tasting

'ANTEPAR'® brand

PIPERAZINE

SYRUP • TABLETS • WAFERS

Eliminate **PINWORMS IN ONE WEEK**
ROUNDWORMS IN ONE OR TWO DAYS

PALATABLE • DEPENDABLE • ECONOMICAL

'ANTEPAR' SYRUP – Piperazine Citrate, 100 mg. per cc.
'ANTEPAR' TABLETS – Piperazine Citrate, 250 or 500 mg., scored
NEW 'ANTEPAR' WAFERS – Piperazine Phosphate, 500 mg.

Literature available on request

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.

Coming Meetings, Postgraduate Courses

MATERNAL MORTALITY INSTITUTES: March 20, Memorial Hospital, Wausau; March 27, Luther Hospital, Eau Claire. Program, presented by State Medical Society and State Board of Health, will be in nature of a CPC conference, with audience participation, on cases presented for review and comment. No registration fee. Application has been made for Category I credit for A.A.G.P. members. See page 88 for information about program.

* * *

AMERICAN ACADEMY OF GENERAL PRACTICE TENTH ANNUAL SCIENTIFIC ASSEMBLY: Dallas Memorial Auditorium, Dallas, Texas, March 24–27.

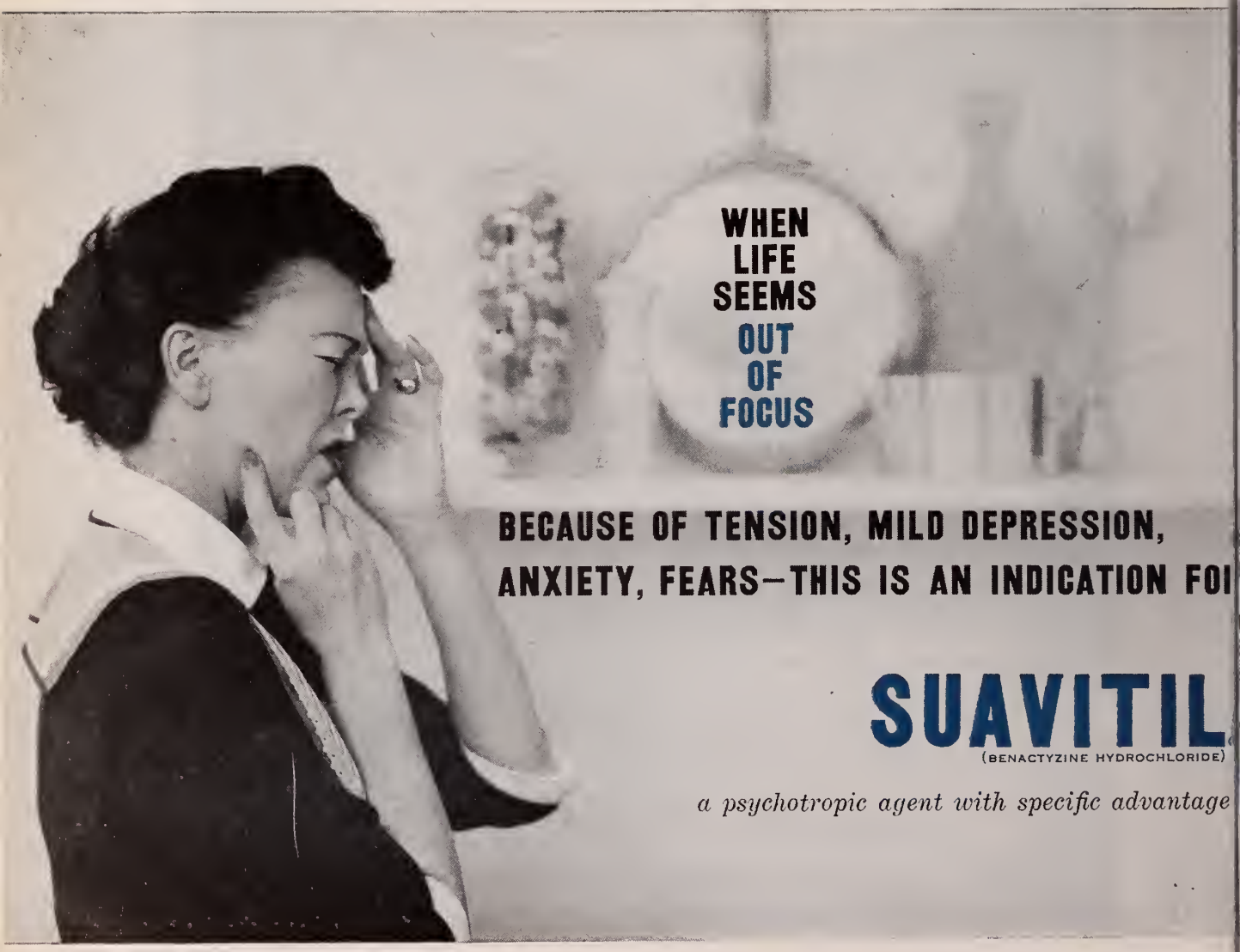
Topics

Monday, March 24:

P. M.—medical, surgical, psychiatric, and adjustment problems of the aging; emotional and physical problems of teenagers

Tuesday, March 25:

A. M.—hazards inherent in surgery of the biliary tract and outlined techniques for full exposure of the "danger zone"; the indefinite pelvic mass, long a gynecologic mystery; efficacy of clinically available antibiotics in pediatric practice; common anemias of infancy and childhood



P. M.—new developments in coronary thrombosis, duodenal ulcers, common skin diseases; the family doctor and his problem eye cases; "The Dizzy Patient—Is it Labyrinthitis?"

Wednesday, March 26:

Four panels: diagnostic x-ray functions; investigation of mistakes resulting from complete dependence on electrocardiograms in determining the presence (or absence) of heart disease; use of forceps, induction of labor, and routine repeat cesarean sections; and prostatism, genitourinary infections, and hematuria.

Thursday, March 27:

A. M.—fractures and hand, head, and neck injuries

P. M.—hypnotism

Wednesday Evening—President's reception and dance—Statler Hilton Hotel, Dallas

WISCONSIN STATE UROLOGICAL SOCIETY: **Manitowoc Hotel, Manitowoc, April 12.** Dr. Justin J. Cordonnier, Washington University, St. Louis, will discuss "Carcinoma of the Bladder" and "Hypertension with Unilateral Renal Artery Disease." For further information contact: R. J. Banker, M. D., 709 Washington Street, Manitowoc.

* * *

CLINICAL REVIEWS, **Mayo Clinic and Mayo Foundation, Rochester, Minnesota, April 14, 15, 16.** Lectures and discussions on problems of current interest in general medicine and surgery presented by staff members of Mayo Clinic and Mayo Foundation. Up to 21 hours of Category I credit may be obtained by American Academy of General Practice members. No fees for program. Attendance necessarily limited. Those wishing to attend should communicate with Mr. R. C. Roesler, Mayo Clinic, Rochester, Minnesota.

RESTORE PERSPECTIVE WITH MILDLY ANTIDEPRESSANT SUAVITIL.

Gently, gradually, without euphoric buffering, SUAVITIL helps patients recover normal drive and helps free them from compulsive fixations.

RECOMMENDED DOSAGE: 1.0 mg. t.i.d. for two or three days. If necessary this dosage may be gradually increased to 3 mg. t.i.d.

MSD MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

Hospital practice of infant feeding

Standard formulas for NEWBORNS

Breast feeding is the procedure of choice for the newborn. But it may need to be complemented with standard formulas given here.

The first feeding, 12 hours after birth, consists of a prelacteal solution of 5% Karo Syrup, one or two ounces, repeated at two-hour intervals. Breast feeding is started on the second day for five-minute intervals and the prelacteal feeding continued immediately thereafter and between nursings.

Formula feeding is given on the second day if breast feeding is denied. The small infant prefers the three-hour schedule and the large infant the four-hour schedule.

The initial formula is a low-caloric milk mixture, gradually increased in concentration over several day intervals according to tolerance. Standard formulas for whole cow's milk or evaporated milk modified with diluted Karo Syrup as shown here, constitute the dietary regimen for well newborns.

First formulas for newborns, concentrated according to tolerance

Evaporated Milk Formulas: 3 oz. q 4h x 6 feedings

	FORMULA I 12.5 cals./oz.	FORMULA II 16 cals./oz.	FORMULA III 20 cals./oz.
Evap. Milk	4 oz	5 oz.	6 oz.
Water	14 oz.	13 oz.	12 oz.
Karo Syrup	1/2 oz.	3/4 oz.	1 oz.

Whole Cow's Milk Formulas: 3 1/2 oz. q 4h x 6 feedings

	FORMULA I 11 cals./oz.	FORMULA II 11.5 cals./oz.	FORMULA III 13.5 cals./oz.
Whole Milk	8 oz.	9 oz.	10 oz.
Water	12 oz.	11 oz.	10 oz.
Karo Syrup	1/2 oz.	3/4 oz.	1 oz.

ADVANTAGES OF KARO IN INFANT FEEDING

Composition: Karo is a superior maltose-dextrin mixture because the dextrins are non-fermentable and the maltose is rapidly transformed into dextrose which requires no digestion.

Concentration: Volume for volume Karo furnishes twice as many calories as similar milk modifiers in powdered form.

Purity: Karo is processed at sterilizing temperatures, sealed for complete hygienic protection and devoid of pathogenic organisms.

Low Cost: Karo costs 1/5th as much as expensive milk modifiers and is available at all food stores.

Medical Division
CORN PRODUCTS REFINING COMPANY
17 Battery Place, New York 4, N.Y.

REMARKABLE EFFECTIVENESS PLUS A SAFETY RECORD UNMATCHED IN SYSTEMIC ANTIBIOTIC THERAPY TODAY

Actually, after almost six years of extensive use, there has not been a single report of a serious reaction to ERYTHROCIN. And, after all this time, the incidence of resistance to ERYTHROCIN has remained exceptionally low.

You'll find ERYTHROCIN is highly effective against the majority of coccal infections and may also be used to counteract complications from severe viral attacks. It comes in *Filmtabs* and in Oral Suspension.

Abbott

802069

Compocillin-V®

for those penicillin-sensitive organisms

802071

Indications

Against all penicillin-sensitive organisms. For prophylaxis and treatment of complications in viral conditions. And as a prophylaxis in rheumatic fever and in rheumatic heart disease.

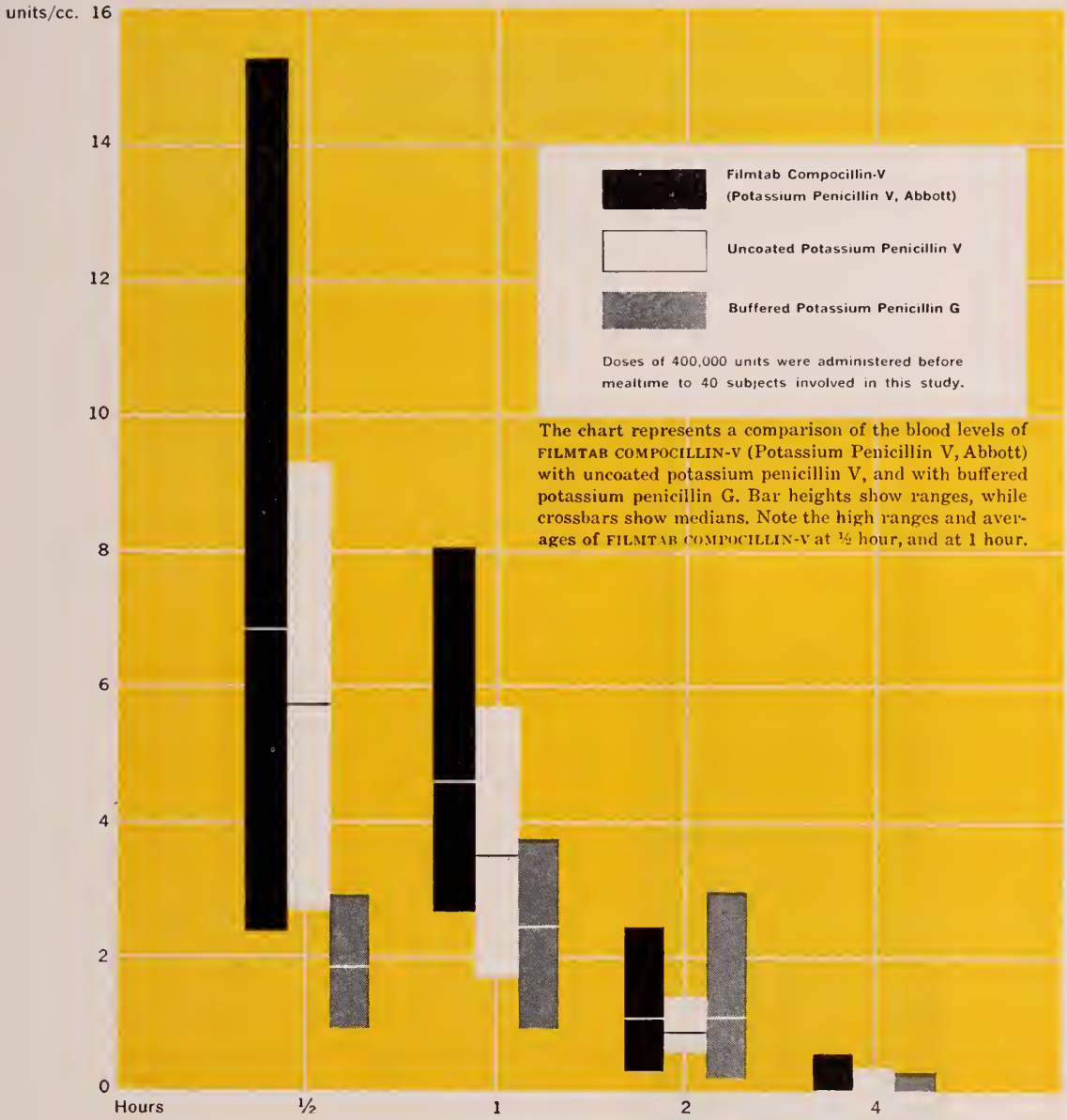
Dosage

Depending on the severity of the infection, 125 to 250 mg. (200,000 to 400,000 units) every four to six hours. For children, dosage is determined by age and weight.

Supplied

Filmtabs COMPOCILLIN-V (Potassium Penicillin V, Abbott) come in 125 mg. (200,000 units), bottles of 50; and in 250 mg. (400,000 units), bottles of 25. Oral Suspension COMPOCILLIN-V (Hydrabamine Penicillin V, Abbott), contains 180 mg. per 5-cc. teaspoonful, in 40-cc. and 80-cc. bottles.

THE HIGHER BLOOD LEVELS OF COMPOCILLIN-V
—IN EASY-TO-SWALLOW FILMTABS AND TASTY, ORAL SUSPENSION



The chart represents a comparison of the blood levels of FILMTAB COMPOCILLIN-V (Potassium Penicillin V, Abbott) with uncoated potassium penicillin V, and with buffered potassium penicillin G. Bar heights show ranges, while crossbars show medians. Note the high ranges and averages of FILMTAB COMPOCILLIN-V at ½ hour, and at 1 hour.

Now, with *Filmtab* COMPOCILLIN-V, patients get (and within minutes) fast, high penicillin concentrations. Note the blood level chart.

COMPOCILLIN-V is indicated whenever penicillin therapy is desired. It comes in two highly-acceptable forms. *Filmtab* COMPOCILLIN-V offers two therapeutic dosages (125 and 250 mg.). Patients find *Filmtabs* tasteless, odorless and easy-to-swallow. For children, COMPOCILLIN-V comes in a tasty, banana-flavored suspension. It's ready-mixed – stays stable for at least 18 months.

Abbott

Spontin®

(Ristocetin, Abbott)

and when coccal infections hospitalize the patient

802079

Indications

SPONTIN is indicated for treating gram-positive bacterial infections. Clinical reports have indicated its effectiveness against a wide range of staphylococcal, streptococcal and pneumococcal infections. It can be considered a drug of choice for the immediate treatment of serious infections caused by organisms resistant to other antibiotics.

Dosage

Recommended dosage depends on the sensitivity of the microorganism and on the severity of the disease under treatment. For pneumococcal and streptococcal infections, a dosage of 25 mg./Kg. per day will usually be adequate. Majority of staphylococcal infections will be controlled by 25 to 50 mg./Kg. per day. However, in endocarditis due to relatively resistant strains or where vegetations or abscesses occur, dosages as high as 75 mg./Kg. per day may be used. It is recommended that the daily dosages be divided into two or three equal parts at eight- or twelve-hour intervals.

Supplied

SPONTIN is supplied as a sterile, lyophilized powder, in vials representing 500 mg. of ristocetin activity.

A LIFESAVING ANTIBIOTIC AFTER OTHER ANTIBIOTICS HAD FAILED

SPONTIN comes to the medical profession with a clinical history of dramatic results — cases where the patients were given little chance of survival.

During these careful, clinical investigations, lives were saved after weeks (and sometimes months) of antibiotic failures. These were the cases where the infecting organisms had become resistant to present-day therapy. And, just as important, were the good results found against a wide range of gram-positive coccal infections.

Essentially, SPONTIN is a drug for hospital use, for patients with potentially dangerous infections. In its present form, SPONTIN is administered intravenously using the drip technique. Dosage may be dissolved in 5% dextrose in water or in any isotonic or hypotonic saline solution. Some of the important therapeutic points of SPONTIN include:

1. successful short-term therapy for acute or subacute endocarditis
2. new antimicrobial activity — no natural resistance to SPONTIN was found in tests involving hundreds of coccal strains
3. antimicrobial action against which resistance is rare — and extremely difficult to induce
4. bactericidal action at effective therapeutic dosages.

SPONTIN is truly a lifesaving antibiotic. It could save the life of one of your patients — does your hospital have it stocked?

Abbott

help reduce
the pressures
IN your
patients

help reduce
the pressures
ON your
patients

for total management
of your hypertensive
patients rely upon

RAUDIXIN

Squibb Whole Root Rauwolfia Serpentina

Raudixin provides gradual, sustained lowering of blood pressure in hypertensive patients, as well as a mild bradycardia. Hence, the work load of the heart is reduced.

"... often preferred to reserpine in private practice because of the additional activity of the whole root."

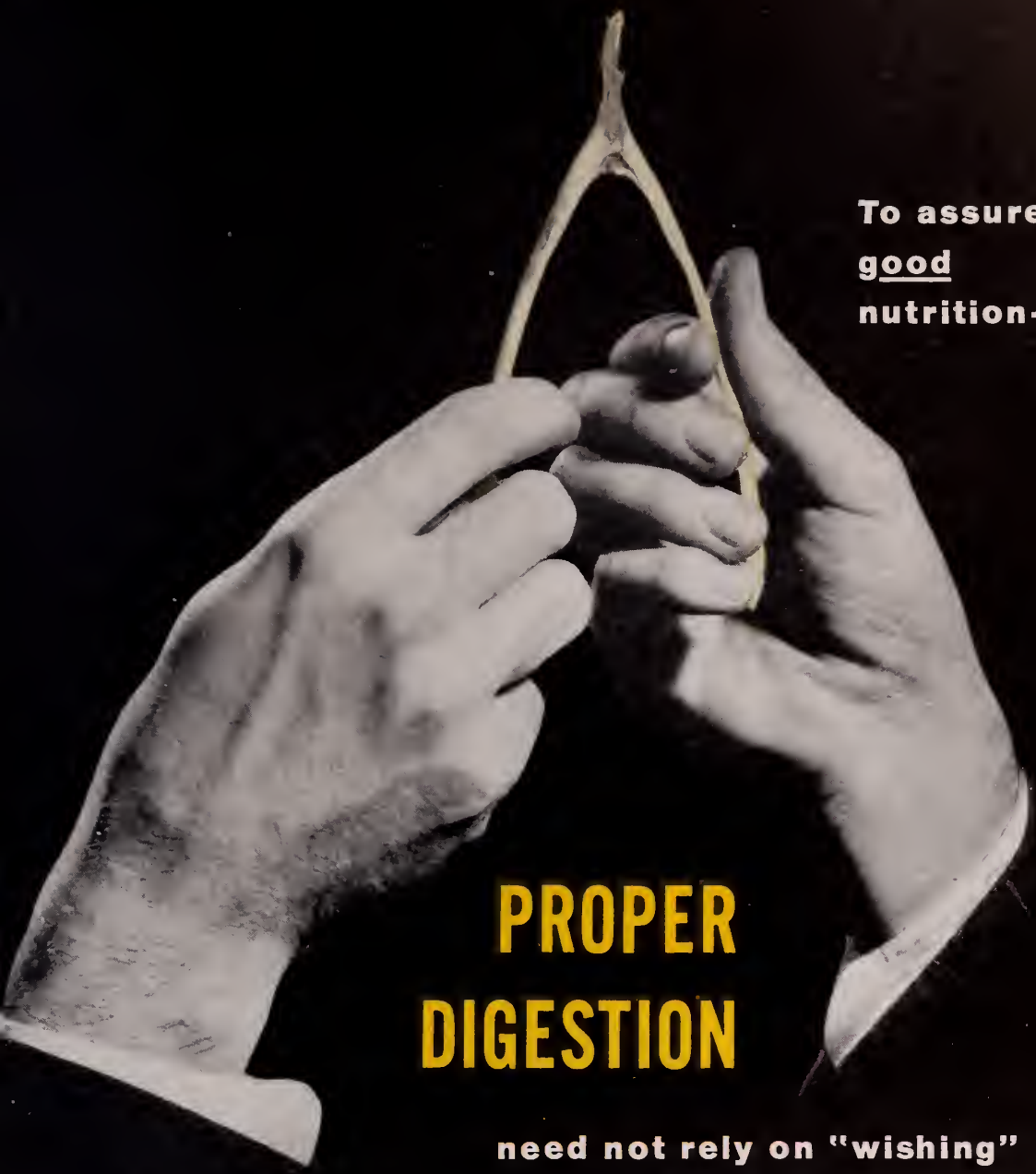
Corrin, K. M.: Am. Pract. & Dig. Treatment 8:721 (May) 1957.

Tranquilizing Raudixin helps relax the anxious hypertensive patient so that he is better able to cope with external pressures without being overwhelmed by them. By reducing these anxieties and tensions, Raudixin helps break the mental tension —hypertension cycle.

Dosage: Two 100 mg. tablets once daily; may be adjusted within range of 50 to 300 mg. *Supply:* 50 and 100 mg. tablets. Bottles of 100, 1000 and 5000.

SQUIBB *Squibb Quality—the Priceless Ingredient*

"RAUDIXIN" IS A SQUIBB TRADEMARK



To assure **good** nutrition—

PROPER DIGESTION

need not rely on "wishing"

Each double-layered Entozyme tablet contains:

Pepsin, N.F. ..... 250 mg.
—released in the stomach from gastric-soluble outer coating of tablet.

Pancreatin, U.S.P. ..... 300 mg.

Bile Salts ..... 150 mg.
—released in the small intestine from enteric-coated inner core.

A. H. ROBINS CO., INC.
Richmond 20, Virginia
Ethical Pharmaceuticals of Merit since 1878

As a comprehensive supplement to deficient natural secretion of digestive enzymes, particularly in older patients, ENTOZYME effectively improves nutrition by bridging the gap between adequate ingestion and proper digestion. Among patients of all ages, it has proved helpful in chronic cholecystitis, post-cholecystectomy syndrome, subtotal gastrectomy, pancreatitis, dyspepsia, food intolerance, flatulence, nausea and chronic nutritional disturbances.

For comprehensive digestive enzyme replacement—

ENTOZYME®

Robins

"ankle-itis"
there's pain and
inflammation here...
it could be mild
or severe, acute or
chronic, primary or
secondary fibrositis — or even
early rheumatoid arthritis

more potent and comprehensive treatment than salicylate alone

assured anti-inflammatory effect of low-dosage corticosteroid[1] . . . additive antirheumatic action of corticosteroid plus salicylate[2-5] brings rapid pain relief; aids restoration of function . . . wide range of application including the entire fibrositis syndrome as well as early or mild rheumatoid arthritis

more conservative and manageable than full-dosage corticosteroid therapy—

much less likelihood of treatment-interrupting side effects[1-6] . . . reduces possibility of residual injury . . . simple, flexible dosage schedule

THERAPY SHOULD BE INDIVIDUALIZED

acute conditions: Two or three tablets four times daily. After desired response is obtained, gradually reduce daily dosage and then discontinue.

subacute or chronic conditions: Initially as above. When satisfactory control is obtained, gradually reduce the daily dosage to minimum effective maintenance level. For best results administer after meals and at bedtime.

precautions: Because SIGMAGEN contains prednisone, the same precautions and contraindications observed with this steroid apply also to the use of SIGMAGEN.

in any case it calls for

Sigmagen®

corticoid-salicylate compound tablets

Composition

METICORTEN® (prednisone)	0.75 mg.
Acetylsalicylic acid	325 mg.
Aluminum hydroxide	75 mg.
Ascorbic acid	20 mg.

Packaging: SIGMAGEN Tablets, bottles of 100 and 1000.

References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

Schering

SQ-J-810

NOW...A NEW TREATMENT

'CARDILATE'*

for THE PROPHYLAXIS OF ANGINA PECTORIS

'Cardilate' tablets shaped for easy retention in the buccal pouch

"... the degree of increase in exercise tolerance which sublingual erythrol tetranitrate permits, approximates that of nitroglycerin, amyl nitrite and octyl nitrite more closely than does any other of the approximately 100 preparations tested to date in this laboratory."

"Furthermore, the duration of this beneficial action is prolonged sufficiently to make this method of treatment of practical clinical value."

Riseman, J. E. F., Altman, G. E., and Koretsky, S.: Nitroglycerin and Other Nitrites in the Treatment of Angina Pectoris. Circulation (Jan.) 1958.

* 'Cardilate' brand Erythrol Tetranitrate SUBLINGUAL TABLETS, 15 mg. scored

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York

when are tranquilizers indicated in pediatrics ?

Some doctors have questioned the use of tranquilizers in children. They feel, and rightly so, that these drugs should not be used as palliatives to mask distressing symptoms, while etiological factors go uncorrected. But there are three situations in which even the most conservative physician would not hesitate to use tranquilizers:

1. When the usually well-adjusted child needs a buffer against temporary emotional stress, such as hospitalization.
2. When a child needs relief from an anxiety-reaction that is in turn anxiety-provoking, so as to pave the way for basic therapy.
3. When anxiety underlies or complicates somatic disease, as in asthma.

In such situations, tranquilizers are likely to be more effective and better tolerated than previously accepted therapy, such as barbiturates.

But the question arises: which tranquilizer is suitable for children?

Most of the physicians now using tranquilizers in pediatric practice have found the answer to be ATARAX, confirming the conclusions of repeated clinical studies.

ATARAX is effective in a wide range of pediatric indications.
ATARAX has produced a "striking response" in a wide range of hyperemotive states.* In a study of 126 children, "the calming effect of hydroxyzine (ATARAX) was remarkable" in 90%.* Among the conditions that are improved with ATARAX are tics, nervous vomiting, stuttering, temper tantrums, disciplinary problems, crying spasms, nightmares, incontinence, hyperkinesia, etc.*

ATARAX is well tolerated even by children.
"ATARAX appears to be the safest of the mild tranquilizers. Troublesome side effects have not been reported. . . ."*

ATARAX offers two pediatric dosage forms.
ATARAX Syrup is especially designed for acceptability by medicine-shy youngsters. A small 10 mg. tablet is also available. In either case, you will get a rapid, uncomplicated response. Why not, for the next four weeks, prescribe ATARAX for your hyperemotive pediatric patients. See whether you, too, don't find it eminently suitable.

*Documentation on request

PEACE OF MIND ATARAX®
(BRAND OF HYDROXYZINE)

M. A. Seidell M.D.
Medical Director

New York 17, New York
Division, Chas. Pfizer & Co., Inc.

ATARAX

in any hyperemotive state

for childhood behavior disorders
10 mg. tablets—3-6 years, one tablet t.i.d.; over 6 years, two tablets t.i.d. Syrup—3-6 years, one tsp. t.i.d.; over 6 years, two tsp. t.i.d.

for adult tension and anxiety
25 mg. tablets—one tablet q.i.d. Syrup—one tbsp. q.i.d.

for severe emotional disturbances
100 mg. tablets—one tablet t.i.d.

for adult psychiatric and emotional emergencies
Parenteral Solution—25-50 mg. (1-2 cc.) intramuscularly, 3-4 times daily, at 4-hour intervals. Dosage for children under 12 not established.

Supplied: Tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

RELIEF

FROM INFECTION*

FROM IRRITATION

*as adjunctive therapy only

THE FIRST TROCHE TO PROVIDE THREEFOLD BENEFITS

'PENTAZETS'

TROCHES

NON-NARCOTIC ANTITUSSIVE EFFICACY SHOWN TO APPROXIMATE THAT OF CODEINE

AND **NOW** COUGH CONTROL TOO

With the addition of a non-narcotic antitussive to troche medication, 'PENTAZETS' provides a new and extended therapeutic advantage in this convenient form of treatment.

Treatment of the cough too, so often a troublesome symptom of sore throat, combined with wide-range antibiotic activity and soothing analgesic benefit, now offers *three*fold relief in a variety of throat irritations.

And 'PENTAZETS' are pleasant-tasting, too, making them highly acceptable, especially to children.

'PENTAZETS' contains:

• *Homarylamine*—a new non-narcotic antitussive with cough control shown to approximate that of codeine. • *Bacitracin-Tyrothricin-Neomycin*—a combined antibiotic treatment against many pathogenic organisms with little danger of unfavorable side effects. • *Benzocaine*—a local anesthetic for soothing relief to inflamed tissues. Being slowly absorbed, it is especially beneficial for prolonged effect and benefit to surrounding areas.

Supplied: Vials of 12.

Each 'PENTAZETS' troche contains:

Homarylamine hydrochloride	20 mg.
Zinc Bacitracin	50 units
Tyrothricin	1 mg.
Neomycin sulfate (equivalent to 3.5 mg. neomycin base)	5 mg.
Benzocaine	5 mg.

MSD

MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

PENTAZETS is a trademark of Merck & Co., Inc.

Published reports confirm—

BETTER PAIN RELIEF

than with a standard APC formula...*

Phenaphen®

In a recent controlled study,* Phenaphen was found more effective than a standard aspirin-phenacetin-caffeine formula for relief of moderate to severe pain . . . with total freedom from side effects and from any tendency to induce drowsiness.

*Murray, R. J.: N. Y. State Jl. Med. 53:1867, 1953.

Each PHENAPHEN capsule contains —

Acetylsalicylic Acid (2½ gr.)	162 mg.
Phenacetin (3 gr.)	194 mg.
Phenobarbital (¼ gr.)	16.2 mg.
Hyoscyamine Sulfate	0.031 mg.

Also available —

PHENAPHEN with CODEINE PHOSPHATE ¼ GR.
Phenaphen No. 2

PHENAPHEN with CODEINE PHOSPHATE ½ GR.
Phenaphen No. 3

PHENAPHEN with CODEINE PHOSPHATE 1 GR.
Phenaphen No. 4

Robins

A. H. ROBINS CO., Inc., RICHMOND 20, VA.

Ethical Pharmaceuticals of Merit since 1878

why wine in Cardiology?

For generations without number wine has been extolled as an "effective stimulant" and, therefore, valuable aid to treatment in various types of cardiovascular disease. It was this peculiar property, no doubt, which prompted the poet, Salerno, some 800 years ago to write—"Sound wine revives in age the heart of youth."

Now, as a result of modern research, we are obtaining concrete evidence of the favorable physiologic action of wine to lend support to the empiricism of ancient usage.

Both brandy and wine in moderate quantities have been found to substantially increase the pulse rate and step up the stroke volume of the heart.

Wine has been found to aid drug therapy in relieving the pain of angina pectoris and obliterative vascular disease.

Moreover, aside from the purely hypotensive actions of wine, its unquestionable euphoric effects help counter the depression, apprehension and anxiety so frequently present in sufferers from heart and coronary disorders.

The beneficial actions of wine appear to transcend those of more concentrated alcoholic beverages—valuable cardiotonic properties having been attributed to the aliphatic aldehydes and other nonalcoholic compounds recently isolated from certain wines and grape varieties.

It goes without saying that the use of alcohol, even in the form of wine, is contraindicated in hypertension accompanied by certain types of renal disease.

For a discussion of the many modern Rx uses for wine, write for the brochure, *"Uses of Wine in Medical Practice"* to Wine Advisory Board, 717 Market Street, San Franciscio 3, California.

where there's a cold
there's

CORICIDIN

when it's a simple cold

CORICIDIN® TABLETS

when it's an all-over cold

CORICIDIN FORTE
CAPSULES

when infection threatens the cold

CORICIDIN with PENICILLIN
TABLETS

when pain is a dominating factor

CORICIDIN with CODEINE
(gr. ¼ or gr. ½) TABLETS◊

when children catch cold

CORICIDIN MEDILETS®

when cough marks the cold

CORICIDIN SYRUP⊙

◊ Narcotic for which oral ℞ is permitted
⊙ Exempt narcotic

SCHERING CORPORATION · BLOOMFIELD, NEW JERSEY

CN-J-228

Schering

puts colds down

gets patients up

CORICIDIN FORTE
CAPSULES

on Rx only

for "get-up-and-go"
METHAMPHETAMINE

• buoys spirits • potentiates pain relief • aids decongestive action

for stress support VITAMIN C

• supplements illness requirements • bolsters resistance to infection

for extra relief ANTIHISTAMINE

• higher dosage strength • optimal therapeutic benefit • virtually no side effects

Each red and yellow CORICIDIN FORTE Capsule provides:

CHLOR-TRIMETON® Maleate (chlorprophenpyridamine maleate)	4 mg.
Salicylamide	0.19 Gm.
Phenacetin	0.13 Gm.
Caffeine	30 mg.
Ascorbic acid	50 mg.
Methamphetamine hydrochloride	1.25 mg.

On Rx and cannot be refilled without your permission

dosage
One capsule every four to six hours.

packaging
Bottles of 100 and 1000.

CORICIDIN,® brand of analgesic-antipyretic.

SCHERING CORPORATION · BLOOMFIELD, NEW JERSEY

Schering

CN-J-328

the bactericidal action makes the difference

In addition to rapid clinical response, 'Ilotycin' provides the important advantages only a bactericidal antibiotic can give you. 'Ilotycin' effectively eliminates strep. carrier states, directly kills pathogens to prevent the emergence of resistant strains, and offers maximum assurance against spread of infection.

Also consider 'Ilotycin' for safer therapy. Allergic reactions following systemic treatment are rare. Bacterial flora of the intestine is not significantly disturbed.

You can achieve more complete antibiotic therapy with 'Ilotycin.'

Usual adult dosage is 250 mg. every six hours.

*'Ilotycin' (Erythromycin, Lilly)

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.

832007

Nilevar®

stimulates protein synthesis, corrects negative nitrogen balance

Increased nitrogen loss, with resulting negative nitrogen balance, occurs in infection, trauma, major surgery, extensive burns, certain endocrine disorders and starvation and emaciation syndromes. The intrinsic control of protein metabolism is lost and a protein "catabolic state" occurs. A patient requiring more than ten days of bedrest usually has had sufficient metabolic insult[1] to precipitate such a "catabolic" phase.

Nilevar (brand of norethandrolone) has been used in patients with varied conditions including hyperthyroidism, poliomyelitis, aplastic anemia, glomerulonephritis, anorexia nervosa and postoperative protein depletion. The patients gained weight and felt better. It was concluded[2] that "the drug certainly caused a reversal of rather recalcitrant or progressive catabolic patterns of disease."

Nilevar is unique among anabolic steroids in that androgenic side action is minimal or absent.

The suggested adult dosage is three to five tablets (30 to 50 mg.) daily. For children 1.5 mg. per kilogram of weight is recommended.

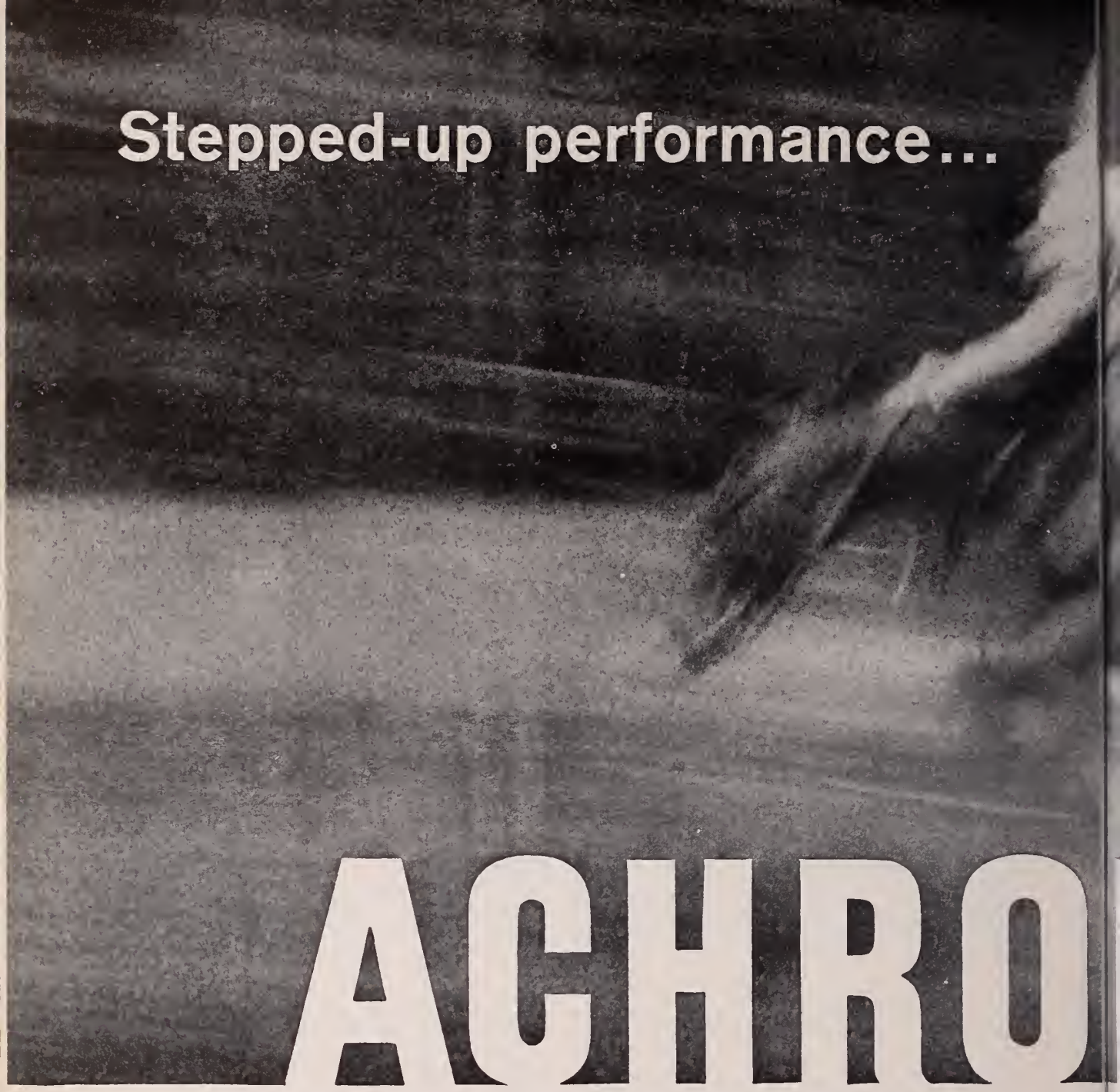
G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

---

1. Axelrod, A. E.; Beaton, J. R.; Cannon, P. R., and others: Symposium on Protein Metabolism, New York, The National Vitamin Foundation, Incorporated, (March) 1954, p. 100.

2. Proceedings of a Conference on the Clinical Use of Anabolic Agents, Chicago, Illinois, G. D. Searle & Co., April 9, 1956, pp. 32-35.

SEARLE



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*Adapted from Wright, S.: Applied Physiology, ed. 8, London, Oxford University Press, 1947, p. 734.

What's wrong with the term "emptying of the gallbladder"?

The gallbladder discharges bile by fractional evacuation. It is not emptied completely at any one time even following a fatty meal.

Source—Lichtman, S. S.: Diseases of the Liver, Gallbladder and Bile Ducts, ed. 3, Philadelphia, Lea & Febiger, 1953, vol. 2, p. 1177.

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Ford, R.V., and Moyer, J.H.: Rauwolfia Toxicity in the Treatment of Hypertension: Some Observations on Comparative Toxicity of Reserpine, a Single Alkaloid, and Alseroxylon, a Compound Containing Multiple Alkaloids, Postgrad. Med., January, 1958.

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Volume 57 FEBRUARY 1958 Number 2

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X-Ray Radiation

The world has suddenly developed a consciousness of the invisible forces of nature which, when harnessed, may be powerful agents for personal and community well-being, but unharnessed or ill-directed may be instruments of death. X-ray radiation is one of these forces which has received dramatic treatment by the press and, indeed, by some medical authorities.

Unfortunately, both physicians and the public have been confused by numerous reports concerning the use and abuse of x-ray radiation, particularly in relation to chest x-ray and chest x-ray surveys.

Fortunately, the profession in Wisconsin has reacted promptly with a survey of the problem and a concise statement for the guidance of physicians. The accompanying statement has been prepared by the Division on Chest Diseases and approved by the Commission on State Departments of the State Medical Society. It has the endorsement of the Wisconsin Radiological Society and the State Board of Health.

This action is a significant demonstration of the worth of the Society's Commission on State Departments. Through this mechanism the Society can achieve a high degree of coordination not only among state agencies and voluntary organizations but among the specialized elements of the profession. Its continued application to other problems will assure improved medical practice and better patient care.

Chest X-ray and Chest X-ray Surveys with Respect to X-ray Radiation

A Statement from the Division on Chest Diseases
Approved By The Commission on State Departments

It is the desire of the Division on Chest Diseases of the Commission on State Departments, State Medical Society of Wisconsin, to attempt to clarify the recent news release from the Office of the Surgeon General of the Public Health Service in regard to x-ray radiation.

A follow-up telegram from the Division of Special Health Services of the Public Health Service stated that "Some versions in the press of the Public Health Service news release on mass x-ray surveys are misleading." The telegram further states, "Mass radiography of the chest, operated under competent auspices, is a fundamental technique in the detection of tuberculosis," and, "A committee of experts has had under review for some time, the problem associated with radiation exposure. It is their considered judgment that the risks inherent in such exposure, although important, are relatively small compared to the very great benefits to be achieved from chest x-ray case finding programs."

News releases relative to the radiation danger due

to radioactive fall-out from thermonuclear explosions have undoubtedly helped to create an exaggerated fear of x-rays in the lay population. From radiology centers such as the New York University-Bellevue Medical Center in New York City, it is reported that many individuals are refusing to submit to essential diagnostic x-ray examinations. These fearful people need to be convinced that the x-ray is indeed one of medicine's indispensable gifts for diagnosis and treatment. It might be well to point out that since the discovery of x-rays in 1895, when tuberculosis was "Captain of the Soldiers of Doom," the mortality rate in this country has dropped from about 194 per 100,000 in 1900 to 9.0 per 100,000 in 1955. A substantial portion of this remarkable achievement is attributable to the wise use of radiological procedure.

It is the impression of the Division on Chest Diseases that the skilled medical men of Wisconsin have a healthy respect for the hazardous effects of radiation, however small. Nevertheless, we wish to offer the following comments and suggestions with respect to the operation of your x-ray equipment:

1. For the population as a whole it is advisable to remain within the limit of 10 r, or 10,000 mr, exclusive of background radiation, with respect to accumulated gonadal dosage, from the period of conception to age 30 years (this averages 0.333 r or 333 mr per year). Exceeding such a limit in a few selected individuals, based upon necessary therapy, would have little bearing on the over-all problem of genetics.

The average individual in the U.S. receives about 100 mr of background radiation per year; *i.e.*, natural radioactivity (cosmic radiation, etc.). If he wears a luminous dial wrist watch he may receive an additional 100 mr per year. A 14 x 17 chest x-ray produces less than 1 mr to the gonadal area. If aluminum filter (2.5 to 3.0 mm.) and rectangular cone are not used, add 10 mr to the gonadal dose. The regular lens type photofluorographic equipment yields up to 5 mr, whereas the mirror optics system reduces this to less than 2 mr.

2. Fluoroscopy should be avoided for screening purposes.

The estimated gonadal dose per adult chest fluoroscopic examination is about 20 mr. With infants, it may exceed 20,000 mr, a figure which should cause great concern to the conscientious physician.

3. For survey purposes with respect to youngsters under 15 years of age, it is best to use the intracutaneous intermediate strength P.P.D. or O.T., rather than to refer these children to the mobile survey units. Of course, positive reactors should have a follow-up 14 x 17 chest x-ray.

4. Keep radiation exposure to minimum by:

(a) Periodic (semiannual) inspection and calibration of x-ray equipment by a qualified physicist.

(b) Strict adherence to the standards set down in Handbook 60 for "X-Ray Protection," National Bureau of Standards (purchasable from Superintendent of Documents, Washington 25, D.C., at a cost of 20¢).

(c) Subscribe to a commercial film-badge monitoring service. Use pocket dosimeters when indicated.

(d) In radiography, utilize to full advantage—faster developer, film and intensifier screens; collimating cones (rectangular) and lead-rubber gonadal barriers for patients.

(e) In fluoroscopy, utilize to full advantage—totalizing timer, "dead-man" switch, lead-rubber gowns (front and back of operator), lead-rubber gloves, smaller shutter opening, longer dark-adaptation time (20 minutes). Keep out "visiting firemen." Protect patient's gonads with lead-rubber apron. Use image-intensifier, and palparium spoon is desirable but not mandatory.

(f) Restrict radiography and fluoroscopy to the lowest limits consistent with medical necessity.

Plan to attend 117th Annual Meeting, State Medical Society, Milwaukee, May 6–7–8

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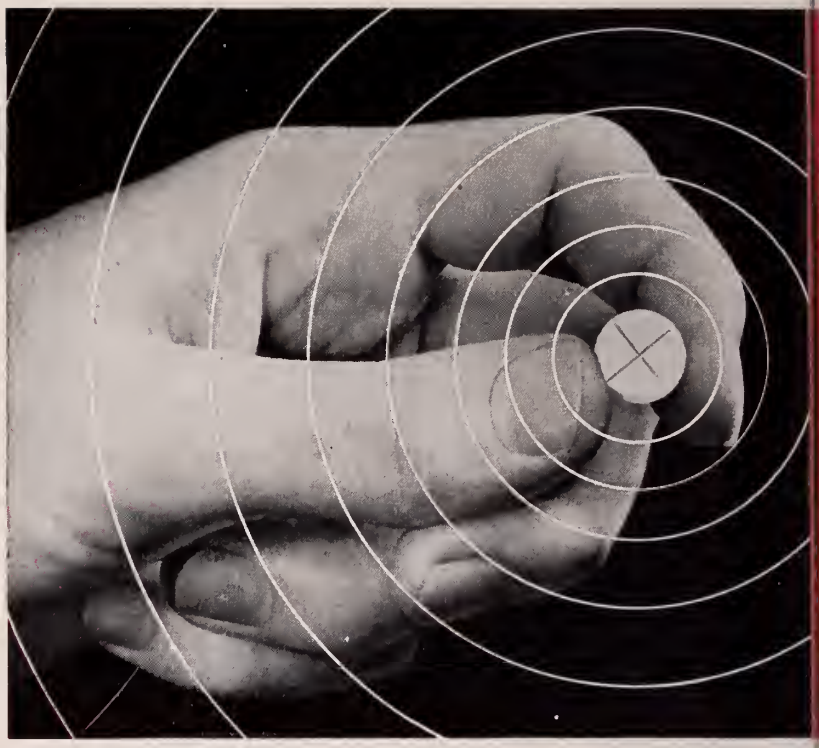
ACS MEETING

SECTIONAL MEETING, AMERICAN COLLEGE OF SURGEONS: March 27–29, Hotel Fort Des Moines, Des Moines, Iowa. Topics will include emergency care of multiple injuries, surgery for congenital lesions, cardiac arrest, cancer, jaundiced patient, ovarian tumors, fluids and electrolytes. Medical motion pictures to be shown daily, with an especially selected program scheduled for Thursday evening, March 27.

ONLY ONE TABLET A DAY



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Tablets:
Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

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Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

[1] Nichols, R. L. and Finland, M.: J. Clin. Med. 49:410, 1957.

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1958 ANNUAL MEETING TIMETABLE

TUESDAY, MAY 6—GENERAL PRACTICE DAY

8:00 a.m. Registration and Exhibits Open

9:00 a.m. General Session

12:15 p.m. Round-Table Luncheons

12:15 p.m. Luncheons of Marquette University School of Medicine and University of Wisconsin Medical School alumni associations

2:00 p.m. General Session

3:00 p.m. New Delegates and Alternates Meeting

6:00 p.m. Buffet for Delegates and Alternates

WEDNESDAY, May 7

8:00 a.m. Registration and Exhibits Open

9:00 a.m. General Session

9:00 a.m. Special Program on Internal Medicine by Residents

12:15 p.m. Round-Table Luncheons

12:15 p.m. Luncheon, Charitable, Educational, and Scientific Foundation

12:15 p.m. Luncheon, Wisconsin Clinic Managers Association

2:00 p.m. Special Programs on Internal Medicine, Obstetrics and Gynecology, Psychiatry, Radiology, Surgical Problems

6:15 p.m. President's Reception

7:00 p.m. Annual Dinner

THURSDAY, MAY 8

8:00 a.m. Registration and Exhibits Open

9:00 a.m. General Session

12:15 p.m. Round-Table Luncheons

12:15 p.m. Past Presidents Luncheon

2:00 p.m. Special Programs on Anesthesia, Gastroenterology, Ophthalmology and Otolaryngology, Pediatrics, Surgery

SPECIAL ASSOCIATED FUNCTIONS....

ON MONDAY, MAY 5

Golf—North Shore Country Club, 134 East Fairy Chasm Road

Tee Time: 10:30 a.m.

Dinner: 7:30 p.m.

ON TUESDAY, MAY 6

Luncheons—University of Wisconsin Medical School Alumni Association

East Room, Fifth Floor, Hotel Schroeder, 12:15 p. m.

Marquette University School of Medicine Alumni Association

Market Hall, Milwaukee Auditorium, 12:15 p.m.

ON WEDNESDAY, MAY 7

Luncheons—Wisconsin Clinic Managers Association

Parlor E, Fourth Floor, Hotel Schroeder, 12:15 p.m.

Charitable, Educational, and Scientific Foundation, Inc., of the State Medical Society of Wisconsin

English Room, Fifth Floor, Hotel Schroeder, 12:15 p.m.

President's Reception, for Dr. and Mrs. H. E. Kasten

East Room, Hotel Schroeder, 6:15 p.m.

Annual Dinner—Professional Talent, Dancing, and Installation of New 50 Year Club Members

Ballroom, Hotel Schroeder, 7:00 p.m.

ON THURSDAY, MAY 8

Luncheon—Past Presidents

Parlor G, Fourth Floor, Hotel Schroeder, 12:15 p.m.

ROUND TABLES

Reinstated last year at the request of many physicians, these discussions stress the newest procedures and information on a wide range of scientific subjects. The Council on Scientific Work urges that you attend.

RESERVATIONS may be made in advance. Remaining tickets may be obtained at the registration desk, Milwaukee Auditorium, until 11:00 a.m. of the day of the luncheon, or at the Hotel Schroeder (fifth floor) up to 12 noon, the same day. *Reserved tickets must be picked up at these times, or will be resold* and a refund given the original purchaser. Tickets secured at time of registration, if not used, must be turned in prior to 11:30 a.m. the day of the luncheon to secure a refund.

Here is the schedule, with all sessions in the Hotel Schroeder, starting at 12:15 p.m.:

TUESDAY

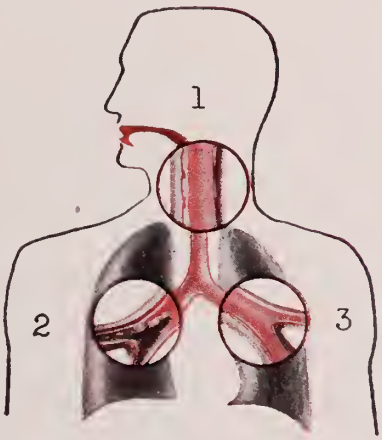
English Room	"Care of the Diabetic Patient" Howard Root, M.D., Boston Moderator: Maurice Hardgrove, M.D., Milwaukee
Pere Marquette Room	"Medical Aspects of the Current Athletics and Sport Picture" J. W. Wilce, M.D., Columbus, Ohio Moderator: Anthony R. Curreri, M.D., Madison
Room 507	"The Evaluation of the Infant or Child Slow in Physical Development" John C. MacQueen, M.D., Iowa City, Iowa Moderator: John L. Garvey, M.D., Milwaukee
Room 508	"The Private Physician and His Relationship to the Public Health Programs" John S. DeTar, M.D., Milan, Michigan Moderator: J. C. Griffith, M.D., Milwaukee

WEDNESDAY

East Room	"Diagnosis and Management of Fetal Distress" Franklin L. Payne, M.D., Philadelphia Moderator: Frederick J. Hofmeister, M.D., Milwaukee
Pere Marquette Room	"Practical Advice to the Present and Prospective Coronary Heart Patient" Ancel Keys, Ph.D., Minneapolis Moderator: J. LeRoy Sims, M.D., Madison
Room 507	"Fractures About the Shoulder" Anthony De Palma, M.D., Philadelphia Moderator: David J. Ansfield, M.D., Milwaukee

(Continued on page 40)

breaks up cough*



*Drawing shows how 3-pronged attack of Pyribenzamine Expectorant with Ephedrine breaks up cough by: (1) reducing histamine-induced congestion and irritation throughout the respiratory tract; (2) liquefying thick and tenacious mucus; (3) relaxing bronchioles. Pyribenzamine Expectorant with Codeine and Ephedrine also available (exempt narcotic). Pyribenzamine® citrate (tripelennamine citrate CIBA). **C I B A**

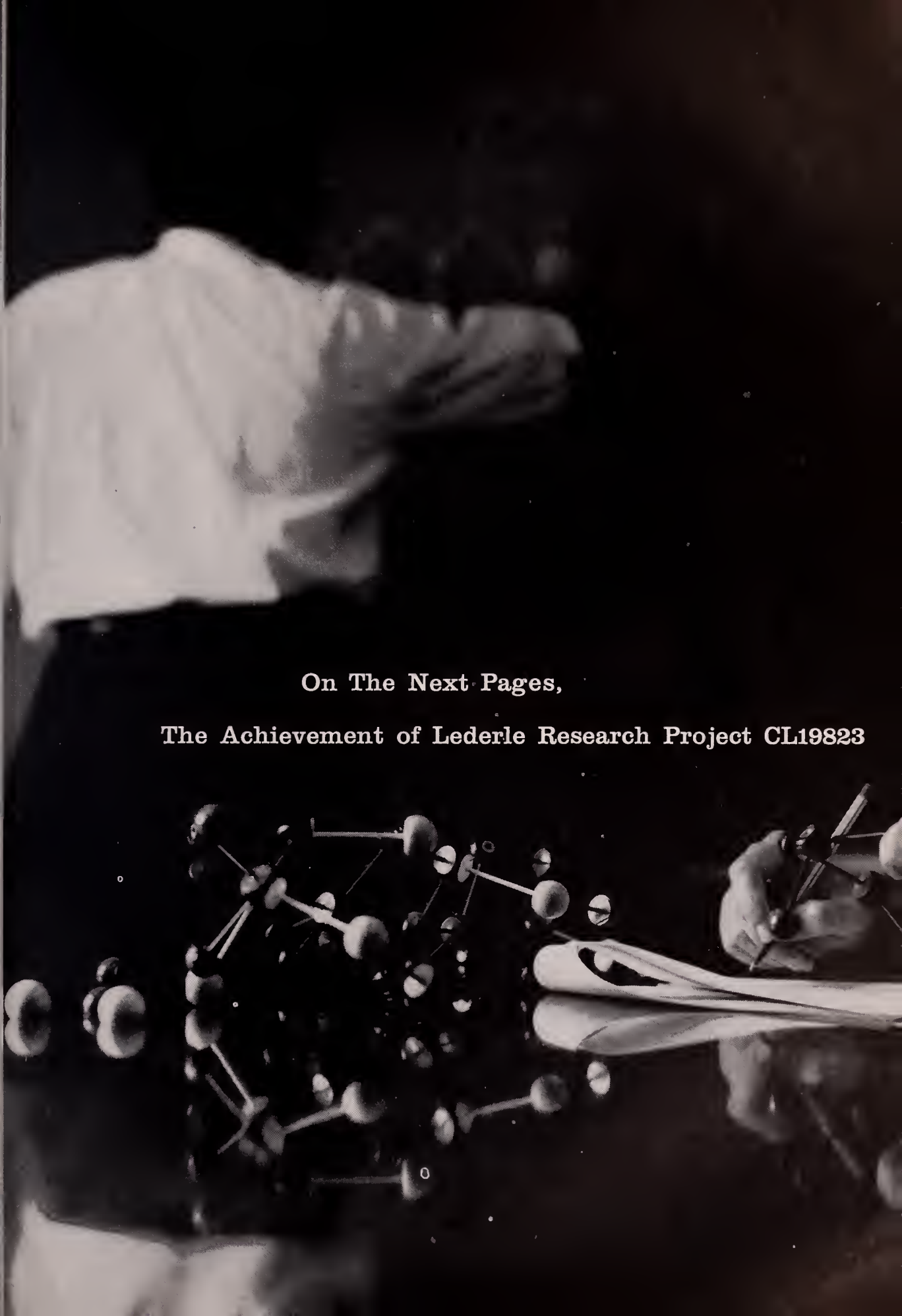
ROUND TABLES

WEDNESDAY—Cont'd.

Room 508	"Trauma and Associated Problems of Emergency Care" Robert D. Pillsbury, Lt. Col., M.C., Fort Chaffee, Arkansas Moderator: Sidney Wynn, M.D., Milwaukee
Parlor A	"Complications of Obstetrical Anesthesia" Virginia Apgar, M.D., New York City Moderator: George S. Kilkenny, M.D., Milwaukee
Parlor D	"Some Practical Aspects of Preventive Psychiatry for Children" Ralph D. Rabinovitch, M.D., Northville, Michigan
Parlor E	"The Solitary Pulmonary Nodule: What Is It and What Should We Do About It?" C. Allen Good, Jr., M.D., Rochester, Minnesota Moderator: Lester W. Paul, M.D., Madison
Club Rooms	"Carcinoma in Situ" James W. Reagan, M.D., Cleveland, Ohio Moderator: Orville R. Kelley, M.D., Wausau

THURSDAY

Pere Marquette Room	"Neonatal Surgical Emergencies" Mark Ravitch, M.D., Baltimore, Maryland Moderator: Shimpei Sakaguchi, M.D., Milwaukee
East Room	Section on Ophthalmology and Otolaryngology
English Room	"The Hazards of Anesthesia" Harold R. Griffith, M.D., Montreal, Canada Moderator: L. F. Thurwachter, Jr., M.D., Milwaukee
Room 507	"The Management of Peritonitis in Infancy" Richard H. Segnitz, M.D., Lexington, Kentucky Moderator: T. V. Geppert, M.D., Madison
Room 508	"Practical Hints in the Management of Common Skin Diseases" Louis A. Brunsting, M.D., Rochester, Minnesota Moderator: David W. Kersting, M.D., Milwaukee
Parlor A	"Current Therapy of Leukemia and the Lymphomas" Howard L. Alt, M.D., Chicago Moderator: John S. Hirschboeck, M.D., Milwaukee
Parlor D	"Most Recent Developments in Regional Ileitis" Burrill B. Crohn, M.D., New York City Moderator: M. C. F. Lindert, M.D., Milwaukee



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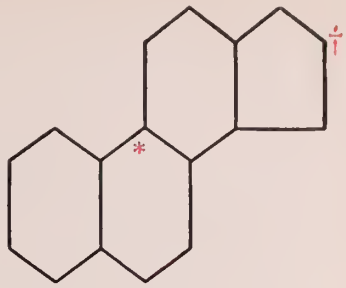

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. . . . THE PRESIDENT'S PAGE . . . .

"Eternal vigilance is the price of freedom"—JOHN PHILPOT CURRAN.

THE specter of national compulsory health insurance is again stalking through our Federal legislative halls. This time it is proposed health legislation introduced in the 85th Congress by Representative Aime J. Forand, a Democrat of Rhode Island. This bill, H.R. 9467, would provide for Federal payment through the social security system of the cost of hospital, nursing, and surgical services for persons eligible for old age and survivors insurance benefits.

It would also liberalize a wide range of social security benefits and increase both ceilings in taxable income and the rate of taxation to provide moneys to meet the added costs. Specifically it would increase the basis on which wage earners are taxed from the present $4,200 to $6,000. In addition, it would increase the tax rate of employees and employers so that within 10 years there would be a tax of 9½ per cent of wages up to $6,000 annually. For self-employed persons the tax would be equal to 7⅛ per cent on the first $6,000 of income.

The proposal is socialized medicine reminiscent of the Wagner–Murray–Dingell bills of 1941 through 1951. The lone difference is that the Wagner–Murray–Dingell bills provided for complete national health insurance for all the people, whereas the Forand bill would apply to a smaller segment of about 12 to 13 million people. It is another adroit scheme of the proponent of national socialization in the over-all strategy of "divide and conquer," and entering through the back door.

I urgently commend for your rereading and thoughtful consideration the address of Dr. David B. Allman, president of the American Medical Association, delivered at the opening session of the House of Delegates at the clinical meeting in Philadelphia, December 3, 1957.

Doctor Allman, in reference to the Forand bill, said in part, "This *is* socialized medicine. This *is* Oscar Ewing's national compulsory health insurance all over again. It *is* the death knell of the young and growing voluntary health insurance industry. It *is* a serious threat to the well-being and local autonomy of the voluntary hospital at the community level. It *is* socialism under the auspices of the Federal Government. Gentlemen, I submit that this bill is at least nine parts evil and one part sincerity.

"Now comes along a new concept, a solution to a problem without first ascertaining its true concept. In short, prescribed treatment without a diagnosis about: (a) the economic resources of our older population, (b) the present and planned programs of voluntary insurers, (c) indigent care at the state level, (d) the incidence of hospitalization and illness by age groups and other complex research questions."

The time for action on this bill is now. Time is of the essence—tomorrow may be too late. Congress is in session now and may act on this bill at any time.

Our legislative committees on both the state and county levels must be alerted to the importance of immediate action. They must conduct a rapid and intensive campaign to educate physicians and legislators regarding the potential evils of this bill.

We have allies who oppose socialism in any form as fervently as we do. We must lose no time in enlisting their active support in the defeat of the Forand bill and all kindred legislation.

Wisconsin must again follow in the footsteps of its traditional medical leadership.

Harry E. Kasten, M.D.

CLINICAL COLLOQUY

My patients complain that the pain tablets I prescribe are too slow-acting... they usually take about 30 to 40 minutes to work.

Why don't you try the new analgesic that gives faster, longer-lasting pain relief?

What is it... how fast does it act?

It's Percodan®—relieves pain in *5 to 15 minutes*, with a single dose lasting 6 hours or longer.

How about side effects?

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STOP respiratory congestion orally

relief in minutes..lasts for hours

In the common cold, nasal allergies, sinusitis, and postnasal drip, one timed-release Triaminic tablet brings welcome relief of symptoms *in minutes*. Running noses stop, clogged noses open—and *stay* open for 6 to 8 hours. The patient can breathe again.

With *topical* decongestants, "unfortunately, the period of decongestion is often followed by a phase of secondary reaction during which the congestion may be equal to, if not greater than, the original condition. . . ."* The patient then must reapply the medication and the vicious cycle is repeated, resulting in local overtreatment, pathological changes in nasal mucosa, and frequently "nose drop addiction."

Triaminic does not cause secondary congestion, eliminates local overtreatment and consequent nasal pathology.

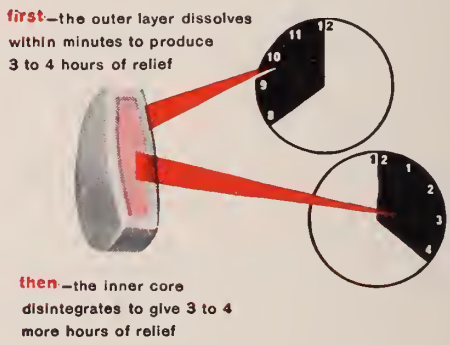
*Morrison, L. F.: Arch. Otolaryng. 59:48-53 (Jan.) 1954.

Each double-dose "timed-release" TRIAMINIC *Tablet contains:*

Phenylpropanolamine hydrochloride	50 mg.
Pyrilamine maleate	25 mg.
Pheniramine maleate	25 mg.

Dosage: 1 tablet in the morning, afternoon, and in the evening if needed.

Each double-dose "timed-release" tablet keeps nasal passages clear for 6 to 8 hours—provides "around-the-clock" freedom from congestion on just three tablets a day



Also available: Triaminic Syrup, for children and those adults who prefer a liquid medication.

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THE MEDICAL FORUM

CITE NEED FOR EMOTIONALLY DISTURBED CHILD CENTER

VOTE AGAINST GROUP EXAMS FOR ATHLETES

MADISON—Physicians in Dane County will no longer give mass physical examinations in schools to pupils planning to participate in athletics.

The Dane County Medical Society Board of Trustees, at a recent meeting, voted to take this stand, saying that hereafter the pupils would be referred to their family physicians for such examinations.

"This change was made to allow the physician to give the pupil a more thorough checkup before he takes part in competitive sports. This can be done best in the physician's office where the necessary facilities and the pupil's history are easily available," Dr. A. P. Schoenenberger, secretary, explained.

The action, he said, was in full accord with the Wisconsin Interscholastic Athletic Association (W.I.A.A.). A letter outlining the recommended procedure was sent to all county schools which are participating in the W.I.A.A. program of athletics. The change is effective this month.

John E. Roberts, W.I.A.A. secretary, told the board that it had taken "a very noteworthy stand, and our organization has never advocated the practice of group examinations."

Wisconsin N-Guard Seeks Physician

SHEBOYGAN—The Wisconsin National Guard is seeking a doctor interested in joining the military group and serving the medical platoon located at Princeton, Wis.

Capt. Arthur J. Krueck, of Headquarters, 2d Battalion, 127th Infantry, based here, asked for the assistance of the State Medical Society and presidents of Fond du Lac, Green Lake-Waushara and Winnebago county medical societies.

Physicians interested in serving in this capacity are urged to contact Capt. Krueck.

Name 11-Man State Mental Health Body

MADISON — Appointment of an 11-member committee on mental health was announced recently by the Wisconsin Legislative Council.

Named to the group were:

State Senators Kirby Hende (R-Milwaukee), Peter P. Carr (R-Janesville) and William R. Moser (D-Milwaukee).

Assemblymen Mamre Ward (R-Mondovi), Emil Hinz (R-Merrill) and Louis L. Mertz (D-Milwaukee).

Public: Mrs. Robert L. Schumpert, Madison, former state PTA president; Mrs. Mary Draheim, Beaver Dam, Dodge County public health nurse, and Atty. George Rice, Milwaukee, assistant corporation counsel for Milwaukee County.

Ex Officio: Dr. Leslie A. Osborn, director of the mental hygiene division, and Fred Delliquadri, director of the division on children and youth, State Department of Public Welfare.

The Legislative Council said the study would concern itself principally with the problems of mental health, with emphasis on the disturbed child, mental retardation and juvenile delinquency. Also, stress is to be placed on problems of increasing health insurance coverage to provide for the treatment of psychological disorders, both on an in-patient and out-patient basis; coordination of state mental health services, and recruitment of professional personnel.

The committee may create an advisory committee of as many members as it wishes who are authorities or interested in this field.

The State Medical Society's Division on Nervous and Mental Diseases has recommended that members of its Sub-committee on the Disturbed Child be authorized as consultants.

. . . MEMO . . .
Milwaukee, May 6-7-8 S.M.S. Annual Meeting

Ask It Be Related To Other Facilities

MADISON — The Division on Nervous and Mental Diseases and its Subcommittee on the Disturbed Child are agreed there is a need for the development of a special state facility, well-integrated with other mental health facilities, for the severely emotionally disturbed child.

Dr. Roland A. Jefferson, Milwaukee, subcommittee chairman, explained that such a facility should be relatively small, and so staffed as to permit expansion as experience and staffing permits. Its operation, he said, should involve close coordination with the University of Wisconsin Medical School so that teaching and research opportunities can be utilized to the fullest while at the same time meeting service needs of the state.

The proposed center would place its emphasis on health care rather than corrections, and thus requires a broadened policy of admission.

A proposal before the 1957 session of the Wisconsin legislature asked for establishment of a treatment center. The measure did not get far, but certain related problems were brought to the attention of the lawmakers, and they, along with physicians, are interested in working out a program.

At the same time, another bill, passed into law, called for creation of an interim study of mental health by a Legislative Council committee. Committee assignments were completed recently (see story in adjoining column), and it is anticipated the study will commence with reports from the State Board of Health, the State Department of Public Instruction and the State Department of Public Welfare.

This committee is expected to create an advisory committee of authorities in the field of mental health.

Dr. Edward D. Schwade, Milwaukee, division chairman, and the Executive Committee of the Coun-

(Continued on page 54)

RECOMMENDED: LIFE INSURANCE AS AN INVESTMENT

Provides Security and Profit, Has Living and Death Values

MADISON—There's one thing certain—you don't have to buy a daily paper to learn how much your life insurance is worth.

You may make an investment in real estate, a common stock, or even a mutual fund, believing, or at least hoping, that it will climb in value . . . and also pay a satisfactory yield on your investment. But very few investments are guaranteed to rise in value, and none guarantees an income except bonds and mortgages. And the yield on them is variable.

Doctors, along with other professional people and wage earners, are searching constantly for some plan of saving and investing money that will provide safety and security for themselves and their families.

The Road to Security has always been a rough, hazardous highway. It has been made more so in the past 40 years by a series of wars and the world's worst depression. High income taxes and low interest rates, influenced greatly by ever-expanding governmental requirements, have increased the difficulties. But as always, safe investment of money requires eternal vigilance, far-reaching knowledge and experience.

Paul J. Rogan, State Commissioner of Insurance, commented:

"Without hesitation, I should recommend that doctors and other professional people avail themselves of the services performed by life insurance companies for the protection of their families against loss of life and for their own protection in old age or in case of prior disability.

"The life companies furnish many suitable forms of protection with variations to suit individual circumstances.

POLICIES VARY

"Thus for the young doctor starting practice a life policy calling for a low premium the first few years may be necessary. Again, the established physician may desire to provide for his old age security by means of an optional annuity or a retirement annuity contract.

"These contracts as well as any other desirable contracts will be described in detail by any life insurance agent."

Physicians, like others, are interested in a simple, fool-proof-as-possible plan which, once it is started, needs little future management, time or attention. For these reasons and others, thousands of MD's and professional people have become more and more interested in life insurance as an investment.

The assets of life insurance consist of all types of property, it is cash in the bank, government and other bonds, farm lands, factories, leading stocks, corporations, homes and buildings.

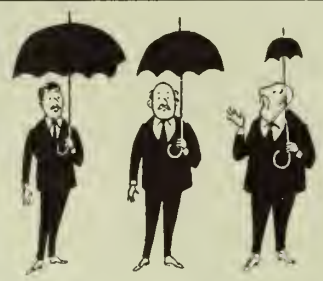
There has never been a failure of a large, well-established life insurance firm. This cannot be said of investments. Life insurance provides either a single sum payment program, or a systematic installment accumulation plan over a span of years. The results are guaranteed.

Life insurance has definite liquidity for the companies. It is usually the last resource an average man will surrender. There is a steady flow of cash in the form of premium income paid to a firm in bad as well as good years.

From 1929 to 1932, the total value of shares listed on the New York Stock Exchange slumped from $90,000,000,000 to $16,000,000,000. Meanwhile, assets of the life insurance companies of America rose from $18,000,000,000 to $21,000,000,000, some 16 per cent.

Another assurance:

Only life insurance promises immediate transfer to beneficiaries without deduction for administration expense, legal fees and certain death taxes. Under certain circumstances, it is immune from the claims of creditors. There is no loss while the estate goes through probate court.



Mr. Paul J. Rogan

In Wisconsin, however, life insurance made payable to named beneficiaries other than the insured's estate is exempt from inheritance taxes only to the extent of $10,000.

For example:

Dr. J. J. died without any estate whatsoever, either solely owned or co-owned with others, but was insured for $50,000. Thirty thousand was made payable to the widow, and $20,000 to his son. There would be the following exemptions:

$15,000 to the widow; $2,000 to the son, and $10,000 to the policy. In other words, $23,000 of the proceeds would be subject to the Wisconsin State inheritance tax.

The law is subject to change, of course, so the benefits may be curtailed or enlarged. The benefits described exist under present statutes.

SPECULATIVE, TOO

Life insurance has been described as a sure thing, but it is also highly speculative. The speculative possibilities always work favorably to the payee, however, and never against him. In the event of premature death, the gain is quite often as much as 5000 per cent.

Another speculative phase is that it is the only property guaranteeing the privilege of borrowing money regardless of business conditions and regardless of the prevailing rates of interest. There are times that banks may not or cannot make loans at any price.

This provides one of the best possible inflation hedges. Many fortunes have been made by those who are canny enough and sufficiently

(Continued on next page)

INSURANCE . . .

(Continued from page 48)

patient to accumulate cash for the buying opportunities that come along, due to deflation rather than inflation.

Many professional people have been saved from financial ruin because of the living values, as well as the death benefits, of life insurance.

The important test of any investment program is "does it work?" Life insurance works; it has for more than 200 years, starting with the Mutual Legal Reserve Life Insurance in London. A century ago, an English author wrote:

"No other investment can combine so well the two great requisites—security and profit. In all the vicissitudes of politics and trade, in time of wild speculation and disastrous panic, in the plethora of peace and exhaustion of war, life insurance investments have been uniformly safe and profitable. Of what other kind of investment can the same thing be said?"

Consider these statistics.

Studies show that $1 of every $20 that the American people earn is invested in life insurance—but nearly $19 of every $20 they have at the "end of the journey of life" are the proceeds of life insurance policies.

You don't have to be a wizard to know what an old man needs in the way of property. You don't have to be a genius to know what a widow with small children needs most of all. The same is true of a man who is disabled or out of a job. The answer, of course, is *income.*

MANY BENEFITS

Old age can last a long time, but it can't last longer than the income from a life insurance policy paid under the annuity settlement options guaranteed in a contract.

Life insurance is a property which, in one contract, assures an increase in cash value, available at any time on demand for emergencies; guarantees the completion of the original program, and pays an income if you become disabled. It serves as a hedge against inflation; assures an income to your family in event of your death and also, if you live, practically all you have paid out will be returned for your dotage, with the privilege of electing a guaranteed life income instead of a lump sum payment.

And that's quite a lot, isn't it?

Mr. Neese

NAME HOSPITAL RELATIONS AIDE

MADISON — Chester C. Neese, administrator of Cumberland Memorial Hospital, has joined the State Medical Society staff as hospital relations consultant.

Neese will supervise a program of closer working relationships between physicians and hospitals in Wisconsin. He also will begin the society's study of the costs of medical care in hospitals.

A native of Iowa, Neese had been administrator of the Cumberland hospital since 1955. Prior to that he was an x-ray technician and administrative assistant with a Minnesota clinic and hospital.

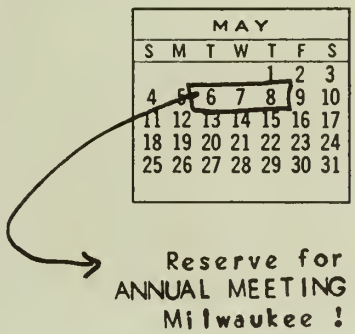
He attended the universities of Iowa and Minnesota.

Women MD's Invited To Miami Congress

MIAMI, FLA. — Women doctors from the United States, Canada, Mexico and Latin American countries are expected to attend the Sixth Congress of the Pan American Medical Women's Alliance here April 14–17.

Wisconsin women physicians interested in attending may write to Dr. Alma Trappolini, 2291 Coral Way, Miami, for information.

Post-Congress trips to the Caribbean and to Washington, D.C., have been arranged.



DR. TENNEY HEADS YOUTH COUNCIL

MADISON—Gov. Thomson recently announced the appointment of the Wisconsin Council on Youth Fitness, a statewide group formulated to place stress on ways and means to improve the physical and emotional status of young people in Wisconsin.

Dr. H. Kent Tenney, jr., of Madison, was named executive director of the council, which was created by executive order.

Members of the group include Dr. Amy Louise Hunter, Mary J. Denton, George E. Watson and Henry Weinlick, Madison; Gelinda E. Vescolani, Wauwatosa; John E. Roberts, Marinette and William Glenn, Milwaukee.

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MILWAUKEE WISCONSIN

Start Listing and Evaluation of Muscular Dystrophy Cases in State

MADISON—A University Hospitals survey team has estimated there are 250 cases of muscular dystrophy in Wisconsin, exclusive of myotonic, myotonic-dystrophic, myositic and neurogenic disorders.

Questionnaires were sent to 3,350 members of the State Medical Society last year. As of December 15, 741 replies had been received. This was described by the research team as an excellent response.

The replies listed 71 patients not previously known to University Hospital muscular dystrophy personnel.

Director of the hospitals' muscular dystrophy clinic is Dr. Henry A. Peters. Two members of the University of Wisconsin Medical School genetics department faculty, Drs. Newton E. Morton and Chin Sik Chung, drafted the questionnaire and with Dr. Peters, studied the replies.

The State Medical Society's Commission on State Departments helped initiate the survey, and aided in setting up the mechanics of its operation.

The Bureau for Handicapped Children, of the State Department of Public Instruction, assisted in the survey, informing physicians of known muscular dystrophy cases. Dr. Patricia E. McIllece directed the bureau effort.

The M-D clinic offers neurological examination, functional evaluation and recommendations by physical therapists, electromyography, and biochemical and general laboratory tests. Admission is by physician's referral only, and hospitalization is seldom required. The patient returns to his physician for treatment and supervision.

NEW RESEARCH

Dr. Peters said therapy is effective for cases of myositis, but the differentiation from dystrophy is being studied primarily.

Dr. Morton is carrying out research on the diagnostic and prognostic values of serum enzyme determinations, with special reference to preclinical and carrier states. Other neuromuscular diseases, include acute poliomyelitis with severe muscle loss, produce little or no elevation of serum enzyme levels.

These changes, Dr. Morton said, may produce a sensitive indicator of success or failure in therapeutic trials.

Dr. Chung is conducting a genetic study of muscular dystrophy that has revealed clinical and prognostic differences among genetic types. His findings include demonstrating for the first time that one type of limb girdle dystrophy does not follow a simple genetic pattern.

Clinical and laboratory data, as well as muscle strength evaluations, are being correlated with family histories to provide a better understanding of the genetic transmission and group classification of dystrophies.

County Society Sponsors Area Essay Contest

PORT WASHINGTON — An essay contest on the topics, "Advantages of Private Medical Care," and "Advantages of the American Free Enterprise System" is being sponsored by the Washington–Ozaukee County Medical Society.

Open to high school pupils in the two counties, the contests will bring awards totaling $200 to the winners, and entry in the national competition directed by the Association of American Physicians and Surgeons.

OFFER NEW POISON REPORT

CHICAGO—Wisconsin physicians are invited to write the Committee on Pesticides, American Medical Association, 535 N. Dearborn St., Chicago 10, for a copy of a new report entitled "Thallotoxicosis—A Recurring Problem."

Growing incidence of thallium poisoning in the past two years indicates a need for discouraging its use as a household chemical, the report states. Restrictions on its use, diagnosis of thallium poison cases and methods of treatment are detailed.

Ask Better Use of School Exam Forms

MILWAUKEE—School administrators should interpret to local physicians their ability to utilize information submitted by the doctors in reporting results of examination of children to school authorities.

This point was stressed during a panel discussion held at the midwinter meeting of the Wisconsin State School Health Council recently.

Drs. F. J. Mellencamp, C. C. Reinke and J. R. Altmeyer, Milwaukee, also recommended the use of the recognized school examination report for students throughout all school systems.

The form was approved by the State Medical Society some years ago, and still is the basic form in the school health field.

The panelists also urged teachers to give more attention to proper utilization of the information provided by physicians as a result of the examinations.

Dr. Mellencamp also discussed the resolution on athletic competition for youngsters under the senior high school level. This was drafted by the society's Division on School Health and approved by its House of Delegates last May.

Dr. H. Kent Tenney sr., Madison, reported on the organization of the Wisconsin Council on Youth Fitness, created recently by order of Gov. Thomson. He is serving the council as executive director.

Dr. Tenney said the council is studying plans to increase stress on both emotional and physical fitness of Wisconsin's young people.

Dr. Amy Louise Hunter, Madison, who serves on Dr. Tenney's council, presided as chairman of the Milwaukee meeting.

REASON TO FEAR

Long term results of the trend toward Big Pensions and its sponsor Big Government are to be feared. Rewards by government for long life to all the people begins a leveling or averaging process that destroys individuality and initiative. It encourages the welfare state by placing responsibility for a great portion of our people solely in the hands of government.

Plan Pilot Study of Restorative Possibilities in Nursing Homes

MADISON — A plan calling for the State Board of Health to conduct a demonstration project to show what can be done in nursing homes to restore bedridden, elderly patients to self-care was endorsed by the Division on Geriatrics at its winter meeting.

Federal funds of $62,200 are available to study some of the service needs in the field of chronic disease and aging.

Dr. Carl N. Neupert, state health officer, and Dr. E. H. Jorris, of the State Board of Health, said the demonstration study would attempt to learn the practicability of restoration to independent community life or to as high a degree as practicable of self-care on the part of such patients in nursing homes. These patients would be those suffering from disability due to chronic diseases.

No such program, it was emphasized, should be undertaken until it has been cleared with the county medical societies concerned.

FUNDS ALLOTTED

The money would be used to pay physicians for physical examinations and evaluation, and for supervising the work of State Board of Health physical therapists in nursing homes. None of the funds would be used for surgical restoration on medical treatment of illness or injury.

Dr. Neupert said that if the project proves workable, the activities demonstrated to be feasible and productive would be assumed later by the community concerned, using available services of special groups such as the Visiting Nurses' Association.

The division expressed its willingness to assist in staging the Second Governor's Conference on an Aging Population in Madison in mid-June. It suggested that the State Board of Health's demonstration project be brought to the attention of those attending the conference. Also proposed were panels on insurance problems of the aged, inroads of health quackery among the aged, and community problems in care of the aged.

The division pledged its support to a plan to hold an institute for nursing home operators and physicians serving nursing homes the day following the governor's conference. The operators and physicians would meet separately in morning sessions, and then join in discussing matters of mutual concern in the afternoon.

Arrangements for the conference and institute are being made by the University of Wisconsin Extension Division, assisted by Dr. Robert C. Parkin, Madison, assistant to the dean of the University of Wisconsin Medical School.

Urge Use of New Television Spots

CHICAGO—County medical societies are being urged to use 10 new 20-second animated TV spots to spur health messages over local stations.

The Bureau of Health Education of the A. M. A. is now preparing the series, taking nursery rhymes and converting them to apt messages. Available without charge, the spots cover colds, first aid, road safety, longevity, cold prevention, harmful toys, nutrition, food preservation, diet and isolation.

The name of local societies will appear at the end of each spot.

RECEPTION GOOD

A recent A. M. A. survey revealed that 90 per cent of all TV station program managers would welcome the jingles as excellent station-break material.

Orders will be taken in the bureau office, 535 North Dearborn St., Chicago 10, or the State Medical Society of Wisconsin, Box 1109, Madison 1.

WARN AGAINST DRUG THEFTS

MADISON — A warning to physicians and pharmacists to take precautions against narcotic thefts was issued recently by the Wisconsin State Crime Laboratory.

In a lead article in the *Law Enforcement Bulletin,* laboratory officials said:

1. Physicians' instrument bags, if left in a car, should be placed in the trunk and locked. Physicians should carry the bags, whenever possible. They should never leave the bags in sight inside an automobile while a car is unattended.

2. If strangers loiter around a drugstore, or make simple purchases that takes them near the prescription section, drugstore employees should write down descriptions of suspects and vehicles, with license numbers if possible. They should also inform store owners so law enforcement officers may be alerted. Surveillance after closing hours may result in apprehension.

BE CAREFUL

3. Narcotics cabinets and lockers may well be hidden in an unlikely spot when the drugstore is closing up at night, to thwart would-be thieves.

The laboratory said Wisconsin physicians and druggists have been victimized more than usual in recent months. Since December 1, instrument bags of five southern Wisconsin physicians were stolen. In most instances, the bags were recovered alongside a country road, minus the narcotics.

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DR. GUNDERSEN: "OPPOSE INDUSTRY-DOMINATED MEDICINE"

Says Demand for Comprehensive Medical Departments Might Be Increasing Soon

MILWAUKEE—Strong opposition to industry-dominated or labor-controlled medicine was voiced by Dr. Gunnar Gundersen, La Crosse, at the 18th annual Industrial Health Congress in January.

Dr. Gundersen, president-elect of the A. M. A., asked Industrial physicians to oppose expansion of occupational health programs into full medical care plans.

"Just as I am opposed to government domination of medicine," he said, "I am also opposed to industry-dominated or labor-controlled medicine."

It was within the scope of industrial health programs to try to prevent non-occupational illness or injury that might cause absenteeism, Dr. Gundersen said, but diagnosis and treatment of such complaints are not proper functions of an industrial health program.

He conceded that so far there has been little pressure for comprehensive medical departments in industry, but the demand for them might be increasing. Industrial physicians should adopt an attitude of "active and total opposition" to the idea, Dr. Gundersen declared.

A few industrial physicians, he said, favor the comprehensive plan . . . "these doctors are empire builders, who seek to extend their influence and their medical domains. Such programs would disturb the doctor and patient relationship, deny free choice of physician to the patient, subject medical care to control of non-medical groups and create small and large medical empires under powerful industrial medical directors."

Dr. Gundersen

COSTLY DISEASE

Dr. Harry R. Foerster, Milwaukee, told the congress that occupational skin disease costs about $100,000,000 annually in this country, and represents about 30 to 40 per cent of all occupational disabilities. Most cases of dermititis, he said, are caused by chemicals, with some 20 per cent being allergic reactions.

Reuben G. Knutson, chairman of the State Industrial Commission, said that if there is a relationship between work factors and heart attacks, industrial commissions need to know how long after "excessive work" an attack can occur.

"It becomes rather disgusting," he said, "to listen to these controversial medical issues (on heart disease). Doctors have furnished us with guides on eye disability, hearing loss and relative permanent disability. They should be able to do the same for cardiovascular disease."

Dr. O. A. Sander, Milwaukee, an industrial medical consultant, told Knutson that the A. M. A. currently has no committee working on a cardiovascular guide for industrial commissions.

Catherine Chambers, R.N., Madison, industrial nursing consultant of the State Board of Health, said many doctors fear that if they accept part-time work as industrial physicians their colleagues will think they are trying to get all the occupational injury work.

This, she said, is a major reason so many small plants lack an industrial health program. A recent survey showed that employers were becoming more interested in industrial health programs, but doctors, she said, are hesitant for fear of causing resentment in the medical profession.

Miss Chambers added that nurses had reported increased cooperation and understanding on the part of doctors.

"There is no longer animosity toward the nurse herself," Miss Chambers said, quoting one report, "because of the feeling she is trying to keep patients from the physician's office."

More than 250 persons attended the two and one-half day session.

Wisconsin MD's Cooperate in Reporting Data

MADISON—The cooperation of Wisconsin physicians participating in research for the National Disease and Therapeutic Index was described by the area coordinator as excellent.

Dr. Douglas H. White, Jr., University Hospitals, Madison, said the purpose of the Index survey is to collect information on the type of patients seen by practicing physicians in everyday practice. It does not include mortality statistics which are available elsewhere.

This type of information, he said, will be of value to the physician, the medical educator and to drug firms in indicating areas where more stress needs to be placed.

Initial report of the N. D. T. I. revealed incidence of neoplasms, also showing site, stage of development.

The index was started in early 1956 as a medical survey project under the direction of a Philadelphia economic research concern. It was sponsored originally by four drug firms. Liaison is maintained with the A. M. A.

Dr. Karver L. Puestow, Madison, is a member of the index' medical advisory committee.

CHANGES . . .

Social security has been changed many times in the 22 years since the original law was enacted. The size and variety of benefits, the tax rates, the tax base, coverage—all have been radically changed. There is no reason to believe that another 22 years will not see just as radical changes.

CHIRO "CURE-ALL" DEVICES APPREHENDED

MADISON—A condemnation suit against nine devices labeled as capable of measuring "nerve interference" and combined with pamphlets claiming the machines will cure any condition of the body has been filed in federal court by U.S. Atty. George E. Rapp.

Rapp said the devices are in the possession of I. N. Toftness, a Cumberland, Wis., chiropractor.

The suit declares that the devices were shipped from the Electronic Instrument Inc., Tiffin, Ohio, to Toftness between November 27, 1956, and July 25, 1957, and were misbranded while held for sale in interstate commerce.

The machines are labeled, "Neurolinometer—Toftness System," Rapp said, adding that if Toftness does not file an answer to the suit, the devices would be destroyed by the U.S. deputy marshal based in Superior.

Rapp said no suit had been filed against Toftness or the Ohio concern. The suit against the devices was instigated by the U.S. Department of Health, Education and Welfare, which asked Rapp's office to make an investigation last fall.

The machines are said to be about as big as a fishing tackle box, and are accompanied with literature which Rapp stated "carry extravagant claims about healing powers, including remedy of abnormal conditions of the kidney, the stomach or any other organ of the body."

DEVICES LEASED

Rapp said Toftness leases or sells the devices to other chiropractors in Wisconsin and elsewhere.

S. C. Syverud, Mt. Horeb, president of the Wisconsin Chiropractic Association, commented:

"The action against I. N. Toftness is certainly not in the same classification as the one in which one Victor Baker, who held a chiropractic license, was attempting to use it to operate a uranium tunnel for treatment purposes.

"In that instance, the State Board of Examiners in Chiropractic acted immediately to file charges of unprofessional conduct and to rescind the operator's license.

"The article in question in the federal action against I. N. Toftness is an analytical instrument designed and used for analytical purposes only. It is not a treatment device but is used to locate the place at which an adjustment should be given.

"The instrument perfected by chiropractor Toftness has been accepted by many chiropractors and used by them successfully . . . and is in no sense a fraud on the public."

Mr. John J. Murphy

MURPHY NAMED TO WPS STAFF

MADISON—John J. Murphy, Madison, has been appointed executive assistant to Claims Director Thomas J. Doran, Wisconsin Physicians Service.

A navy veteran, Murphy formerly was employed by insurance firms in Madison and Philadelphia as an adjustor and supervisor.

He is a graduate of the University of Wisconsin, with a degree in social work.

Hoxsey in Trouble Again

CHICAGO—Troubles continue to pile up for Harry M. Hoxsey.

Recently, according to an A.M.A report, Dist. Judge Charles E. Long jr., issued an injunction barring Hoxsey from practicing medicine in Texas, conducting a business known as the Hoxsey Cancer Clinic, and collecting fees for services to clinic patients before May 1, 1957.

The court did not act on a request by the Texas Board of Medical Examiners to invalidate a lease agreement between Hoxsey and an osteopath, Harry Taylor, who now runs the clinic. Taylor reportedly is paying Hoxsey a rental of $2,500 a month, or 50 per cent of patients' fees, whichever is greater.

Push Medical C–D Plans in Milwaukee County

MILWAUKEE—Organization of an advisory committee to assist the medical-hospital services division of the Milwaukee Metropolitan Civil Defense commission was announced recently.

The commission is responsible for developing and coordinating hospital disaster planning with state and county medical plans. It also will direct the training of professional and technical personnel in disaster techniques, including orientation of medical personnel with an emergency 200-bed mobile hospital unit.

Represented at the organization session were the Red Cross, Milwaukee Hospital Council, Wisconsin Society of X-Ray Technicians, Milwaukee Nurses' Association, Greater Milwaukee Dental Society, Milwaukee County Medical Examiner's office, Milwaukee Society of Medical Technologists, Milwaukee District Society of Osteopathic Physicians and Surgeons, Milwaukee County Pharmacists' Association and the Milwaukee Veterinary Medical Association.

The Dane County Civil Defense office reported it was developing its program from the national disaster plan, working with allied organizations and holding special training courses for professional personnel.

A.M.E.F. REPORTS CONTRIBUTIONS

CHICAGO—The American Medical Education Foundation recently reported contributions from the following Wisconsin physicians:

Drs. Harry Ageloff, Racine; H. W. Bardenwerper, Waterford; S. S. Blankstein and Samuel W. Rosenberg, Milwaukee; Gunnar Gundersen, La Crosse; Walter Lewinnek, Merrill; Carl N. Neupert, Madison, and L. C. Pomainville, Wisconsin Rapids.

NATIONAL ASSOCIATION FOR MENTAL HEALTH
Fight Mental Illness

Hospital Relations Program Outlined

MADISON—Proposals for hospital relations activities during the next year were approved at a joint meeting of the Council on Medical Service and the Committee on Hospital Relations recently.

Specific planning outlined the following:

A program of visiting representative hospitals in all sections of the state to survey physician-hospital relations, and to gain a familiarity with physicians and hospital personnel. Detailed reports of such visits will be available later for committee consideration.

1. The accumulation of rules, regulations and bylaws of all hospitals in Wisconsin with a view to their review for bringing them in line with more recently accepted principles and practices in the field.

2. A review and statistical analysis of general and allied special hospital facilities, with stress on location, administration, ownership, beds, admissions and accreditations, to serve as a ready reference.

3. Continued liaison with hospital medical staffs, so that they might have the assistance of the State Medical Society more readily available. Concerned would be such matters as routine charges for all tissue sent to laboratories, regardless of pathology, and questions of ethics and legality of services provided by assistants in surgery.

An initial draft of a medical-press guide, authorized by the Council in 1957, was reviewed by the Council. Suggestions for several changes were made, and the group will be asked to survey another draft at a later date. State radio, television and newspaper personnel are cooperating in the project.

The council was informed that several colleges in the state had expressed interest in establishment of a one-year course for training medical assistants.

Dr. Joseph S. Devitt, Milwaukee, council chairman, appointed a committee to assist officers of the Wisconsin State Medical Assistants' Society in getting the course installed. Named were Drs. H. J. Kief, Fond du Lau, J. F. Maser, Rice Lake; D. M. Willison, Eau Claire, and S. W. Hollenbeck of Milwaukee.

Reports on utilization of *Health News*, monthly publication sent by the State Medical Society to 450 industrial firms in the state, and health tapes, sent to high schools, were received. The council agreed that popularity of the services deserved a continuance of both programs.

CONSIDER!

American medicine would do well to study the plight of physicians in Britain and France before accepting financial arrangements that would make them sitting ducks for capture by Government.

CHILD CENTER . . .

(Continued from page 47)

cil of the State Medical Society have recommended to the Legislative Council that members of the Sub-committee on the Disturbed Child serve as consultants to the mental health study.

It is obvious, Dr. Jefferson told the division, that treatment centers cannot take over the assignment of handling all children. He said emotional problems do not lend themselves to the same type of care as medical treatments for other types of maladies. For this reason, it must be made clear, he said, what a treatment facility could and could not do for its young patients.

COMMITTEE NAMED

Dr. Schwade appointed a committee to study the subject of tranquilizers and report back to the group with a view of making the findings available to the society as a whole. Named to the committee were Drs. Walter J. Urben and T. J. Nereim, Madison; Keith M. Keane, Appleton and Henry Veit of Milwaukee.

The division members were urged to attend, when possible, annual sessions of the A. M. A. Conference on Mental Health. Drs. Schwade and A. A. Lorenz, Eau Claire, who attended in 1957, described the conference as an extremely effective force for keeping informed of developments in the field and for exchange of ideas.

HOW WE BREATHE—a new A.M.A. display, one of many available for use by county medical societies and medical organizations. It stresses the organs of breathing, air passage, voice box, action of breathing, the lungs, and why we breathe. The State Medical Society of Wisconsin will assist in arranging for various displays.

On the S.M.S. Calendar

MARCH

1– 2—Annual Meeting, General Council, S.M.S.

5 —Claims Committee, S.M.S.

6– 8—A.M.A. Rural Health Conference, Jackson, Miss.

15–16—Quarterly meeting, Commission on Medical Care Plans, S.M.S.

APRIL

2—Claims Committee, S.M.S.

MAY 6–8 — ANNUAL MEETING, STATE MEDICAL SOCIETY, MILWAUKEE!

Society Proceedings*

Ashland–Bayfield–Iron

Ashland–Bayfield–Iron doctors heard *Dr. Howard L. Correll,* Marquette University, speak on "New Concepts and Management of Coronary Disease" at a meeting held December 16 at the Platter in Ashland. During the business session *Dr. H. V. Sandin* was elected president and *Dr. C. A. Grand* secretary. Legislation was discussed and also there was discussion of the group life insurance program now offered members.

Brown

At the November 14 meeting of the Brown County Medical Society, resolutions in favor of a full-time city health officer for Green Bay and ultimate establishment of a city–county health department were passed unanimously. At present, *Dr. Frank Urban,* Green Bay, is serving as acting city health officer on a part-time basis. The State Board of Health has also recommended a full-time health officer to meet the medical needs of an expanding Green Bay.

The society met on December 10 at the Elks Club in Green Bay for the annual election of officers. *Dr. George Nadeau* was installed as president, and elected to serve with him were *Drs. Donel Sullivan,* president-elect; *Frank Urban,* secretary–treasurer; *Louis Milson,* censor for a term of three years; *L. C. Miller,* delegate; *J. L. Ford,* alternate delegate; *R. M. Waldkirch,* De Pere, delegate; and *S. L. Griggs,* alternate. All of the officers, except where otherwise noted, are from Green Bay.

Chippewa

Dr. B. J. Haines of Cadott was elected president of the Chippewa County Medical Society at the November meeting of the organization held at the Hotel Northern in Chippewa Falls. Other officers named include *Dr. William F. Janc,* Chippewa Falls, vice-president; *Dr. R. L. Hendrickson,* Cornell, secretary–treasurer; *Dr. John J. Sazama,* Chippewa Falls, delegate; and *Dr. B. F. Rahn,* Chippewa Falls, alternate delegate.

Columbia–Marquette–Adams

The quarterly meeting of the Columbia–Marquette–Adams County Medical Society was held on December 9 at the Owl's Nest in Poynette. The

* Physicians whose names are printed in italics are members of the Society.

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William L. Herner, M. D., Medical Director

John F. Wyman, M. D. — Lloyd F. Jenk, M. D.

Hubert H. Blanchard, M. D. — Richard O. Barnes, M. D.

John E. Leach, M. D. — John R. Whitty, M. D.

Preston W. Thomas, M. D.

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the fever

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business meeting was followed by a social hour and dinner. The society named *Drs. H. A. Winkler*, Pardeeville, president; *C. F. Broderick*, Wisconsin Dells, president-elect; and *T. S. Westcott*, Pardeeville, secretary–treasurer for the coming year.

Dane

"The Diagnosis of Kidney Disease (from a Clinical Standpoint)" was the title of a paper presented before the November 12 meeting of the Dane County Medical Society. The speaker, *Dr. A. P. Crosley, Jr.*, of Madison, addressed the members of the society at the State Medical Society building.

Dodge

Sister Gervase, superintendent of the Waupun Memorial Hospital, spoke to members of the Dodge County Medical Society when they met at the hospital on November 21. She discussed her trip to Europe and a study done of nursing problems in European hospitals. During the business portion of the meeting, the society elected *Dr. Robert F. Boock*, Beaver Dam, president and *Dr. George G. Drescher*, Beaver Dam, secretary–treasurer for 1958.

Door–Kewaunee

Dr. and Mrs. *J. F. March*, Algoma, were hosts at a Christmas party held on December 8 for members of the Door–Kewaunee Medical Society. A 6:30 potluck dinner was followed by a social evening. Twenty-four people attended.

Fond du Lac

At a meeting held in the Elks Clubhouse in Fond du Lac, *Dr. John C. McCullough* was elected new president of the Fond du Lac County Medical Society. He succeeds *Dr. Hugh J. McLane*. Other officers chosen were *Dr. Edward W. Vetter*, vice-president; *Dr. Robert W. Schroeder*, secretary; and *Dr. W. E. Myers*, treasurer. All of the physicians are from Fond du Lac.

Members discussed at length the Asiatic flu problem and then passed and adopted a resolution noting that there are two approved methods of administering the flu vaccine. The resolution also stipulated that Fond du Lac County would follow the priority system for giving injections as suggested by the State Board of Health and the State Medical Society.

Jefferson

The annual business meeting of the Jefferson County Medical Society was held at the Meadow Springs Country Club in Jefferson on December 19, with 23 members present. The annual treasurer's report and the report of delegates to the State Medical Society Annual Meeting were given. Election of officers was held, and the following physicians will serve during 1958:

President: *E. E. Burzynski*, Watertown
Vice-President: *J. R. Fowler*, Waterloo
Secretary–Treasurer: *E. P. Schuh*, Watertown
Censor: *S. H. Ambrose*, Whitewater

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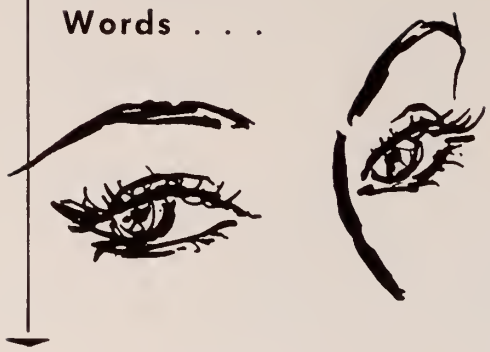

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Kenosha

Forty-seven members of the Kenosha County Medical Society met at the Elks Club in Kenosha on November 7 to hear an address by *Dr. J. F. Kuzma* of Milwaukee. The guest speaker, who is professor and director of the pathology department at Marquette University School of Medicine, chose "Radioactive Strontium" as the title of his talk. During the business session, a new health and accident insurance form was presented to the members, and reports by chairmen of two committees were heard.

The annual election of officers was held when 45 members of the society met on December 5. The new president is *Dr. W. C. Kleinpell;* president-elect, *Dr. J. B. Pearson;* delegate, *Dr. Harry L. Schwartz;* alternate delegate, *Dr. Richard Ashley;* and executive secretary, Mr. Lee F. Jost.

In other business conducted at the meeting, the society voted to send a check for $500 to the Medical Museum fund, this in addition to the individual contributions from members; and a report was given by *Dr. Paul Lawrence*, superintendent and medical director of Willowbrook Sanitarium and the Kenosha County Home, on the medical work at each institution.

Marathon

At its annual meeting at the Wausau Club on December 5, the Marathon County Medical Society installed *Dr. J. V. Flannery*, Wausau, as its president for the coming year. He succeeds *Dr. Helen Crawford Davis*, Wausau, who presided at the dinner meeting. *Dr. Marvin Olson*, Wittenberg, was chosen president-elect, and *Dr. Roy B. Larsen*, Wausau, was re-elected secretary–treasurer.

Marinette–Florence

Members of the Marinette–Florence County Medical Society met on December 18 at the Riverside Country Club to elect officers for the coming year. The following physicians were chosen to serve:

President: *C. H. Boren*, Marinette
President–Elect: *R. B. Pelkey*, Pound
Secretary–Treasurer: *K. G. Pinegar*, Marinette
Delegate: *C. E. Koepp*, Marinette
Alternate Delegate: *J. W. Boren*, Marinette
Board of Censors: *R. B. Pelkey*, Pound
G. R. Duer, Marinette
R. J. Rogers, Oconto

Milwaukee

The scientific session of the first fall meeting of the Medical Society of Milwaukee County featured a program on automobile accidents and other injuries. The panel of speakers included Drs. Harold C. Voris, Chicago; Robert E. L. Berry, Ann Arbor, Michigan; and William M. Tuttle, Detroit.

Dr. S. A. Morton was installed as president for the coming year when the society held its annual meeting at the Wisconsin Club on December 12. *Dr. Joseph S. Devitt* was selected president-elect and other officers chosen include *Dr. Lamont R. Schwei-*

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1. Waldman, S., and Pelner, L.: Am. Pract. & Digest Treat. *8*:1075 (July) 1957.

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ger, secretary, and *Dr. William F. Hovis, Jr.*, treasurer.

A special feature of this meeting was an address by *Dr. Gunnar Gundersen*, La Crosse, president-elect of the American Medical Association. His address was titled "Medicine—a Way to Promote Peace."

Outagamie

Dr. George A. Behnke, Kaukauna, was elected president of the Outagamie County Medical Society when members met at the Riverview Sanatorium in Kaukauna on October 17. Other officers include *Dr. H. T. Gross*, Appleton, vice-president; *Dr. George A. French*, Appleton, secretary; *Dr. Guy W. Carlson*, Appleton, delegate; and Doctor Gross, alternate delegate. Other items on the agenda included reports from the delegates to the Annual Meeting of the State Society and a report on the Blood Center. The society approved support of the newly formed Community Guidance Center, which is attempting to correlate aid to all emotionally ill children up to 18 years of age, and also approved a resolution in favor of social security. Fifty members attended this session.

Forty-eight members were present when the society met at the Elks Club in Appleton on November 21 to hear a talk by *Dr. Keith M. Keane*, Appleton, on psychiatric problems. The lecturer also showed a movie on psychoneurotic problems. Members also heard a preliminary announcement concerning the group life insurance program now available through the State Society. Mr. W. L. Storer, a representative of Bankers Life Insurance, presented the talk.

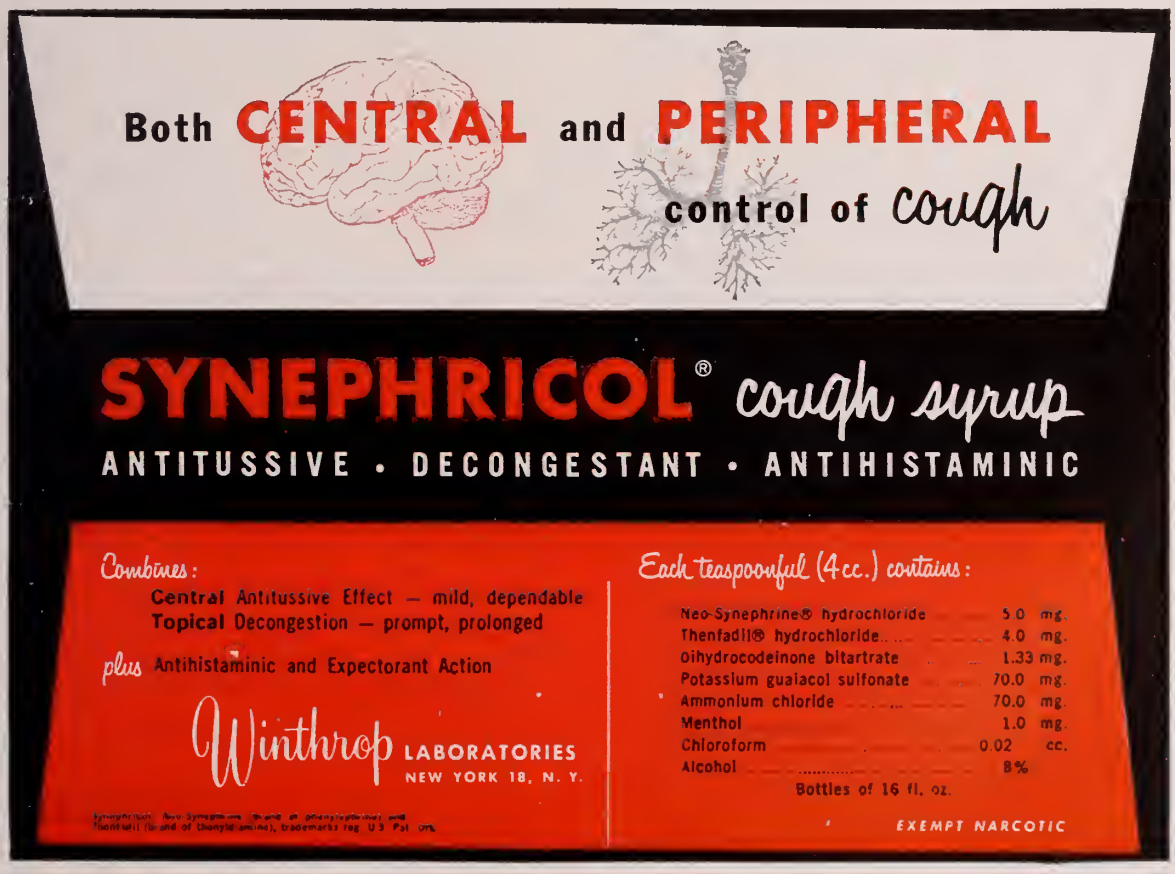
The annual meeting with the Auxiliary brought 118 physicians and their wives to the December 19 meeting of the society. Mr. Murl Deusing, curator of education at the Milwaukee Public Museum, showed movies and spoke on his trip to Africa. A special feature of the program was the presentation of a plaque to the outgoing president, *Dr. James W. Laird* of Appleton.

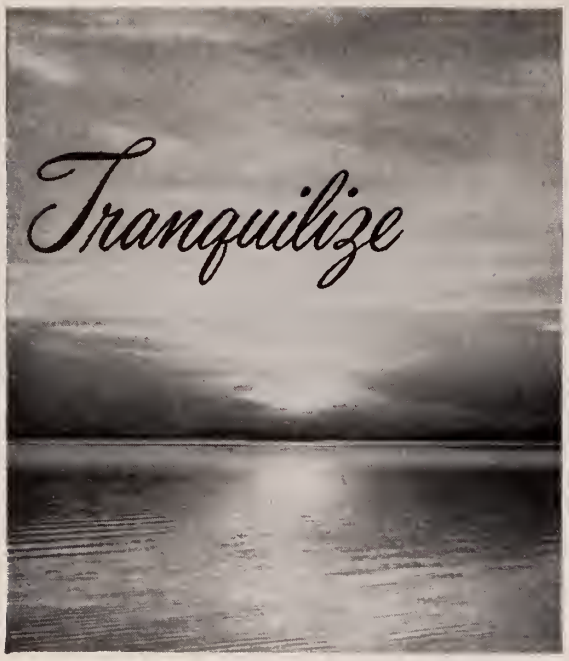
Pierce–St. Croix

On October 22, a meeting of the Pierce–St. Croix Medical Society was held at Marsel's Steak House, Somerset. Members of the society met at the home of *Dr. A. R. Aanes*, Ellsworth, on November 26. The December meeting of the society was held at the Dibbo Hotel in Hudson on December 17.

Polk

The Polk County Medical Society held a joint meeting with the Polk County Attorneys Association on October 17 at the Dalles House in St. Croix Falls. The host for this meeting of 30 physicians and attorneys was *Dr. W. C. Andrews* of Frederic. Mr. Louis G. Nagler, a St. Croix Falls attorney, showed the film, "The Medical Witness," and led a





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round-table discussion regarding the relationship of doctors and lawyers. New officers were elected for the next year; the slate consists of: *Dr. Stella I. Burdette*, Balsam Lake, president; *Dr. Marwood Wegner*, St. Croix Falls, vice-president; *Dr. Lewis J. Weller*, Osceola, secretary–treasurer; *Dr. L. O. Simenstad*, Osceola, delegate; *Dr. Robert M. Moore*, Frederic, alternate delegate; and Doctor Weller, Osceola, censor. *Dr. F. L. Whitlark* of Amery was appointed to be in charge of the local fund raising for the Medical Museum. In other actions taken at this meeting the society voted to cooperate with the Polk County Public Health Council in the tuberculin testing of pupils in selected grades in the schools throughout the county.

The December 12 meeting of the society was held jointly with its Auxiliary. The doctors and their wives were the guests of *Dr.* and Mrs. *David Maas*, Webster, at Perry's in Siren. Following dinner separate business sessions were held by the society and the Auxiliary. The doctors' program consisted of a discussion by each individual of his most interesting case.

Racine

"The Other City," a short film on cancer which was made in Racine with local scenes and actors, was one of the features of the November 21 meeting of the Racine County Medical Society. The members also elected the following Racine physicians as officers for the coming year:

President, *Leo Lifschutz*
President-Elect: *Louis Kurten*
Vice-President: *William Bennett*
Secretary: *Warren Williamson*
Treasurer: *C. W. Christenson*

As in the past, the new officers were officially installed at the annual dinner-dance, which was held on December 10 at the Racine Country Club.

Rock

Dr. Victor S. Falk, Edgerton, was elected president of the Rock County Medical Society at the October 22 meeting at the Hotel Hilton in Beloit. Other officers who were elected to serve with him are *Dr. Joseph Springberg*, Beloit, vice-president; *Dr. Eugene S. Hartlaub*, Janesville, secretary–treasurer; *Dr. John Holmes*, Milton Junction, board of censors; and *Dr. David Cohen*, Edgerton, board of trustees. Thirty members attended this meeting.

Sauk

The annual meeting of the Sauk County Medical Society was held on December 10 at the Warren Hotel in Baraboo. The following officers were selected for the coming year:

President: *M. F. Huth*, Baraboo
President-Elect: *G. W. Zauft*, Prairie du Sac
Secretary: *John J. Rouse*, Reedsburg
Delegate: *B. E. McGonigle*, Baraboo
Alternate: *C. R. Pearson*, Baraboo

Delegate to Charitable, Educational, and Scientific Foundation: *Milton Trautmann*, Prairie du Sac

In other business transacted, the nursing committee recommended that four scholarships be awarded for the 1958 school year, and representatives of the Bankers Life Insurance Company explained the new group life insurance plan of the State Society.

The guest speaker for the scientific part of the program was *Dr. A. R. Tormey, Jr.*, of Madison. The title of his talk was "Diseases and Treatment of the Prostate Gland."

Sheboygan

S. E. Gavin, Jr., State Medical Society counsel, was the guest speaker at the October meeting of the Sheboygan County Medical Society. He outlined the processes by which the medical profession is able to present its views to legislators and, on request, to assist in the drafting of bills in the health field. Several of the over 200 medical and public health bills submitted were discussed by the group.

The members also heard a report on the progress being made in restoration of Fort Crawford Military Hospital, Prairie du Chien.

When the society met on November 21 at Memorial Hospital, the membership elected *Dr. Joseph Russell*, Random Lake, for the post of president. Other officers, all of Sheboygan, are *Dr. Robert Wood*, vice-president; *Dr. Robert Senty*, secretary-treasurer; *Dr. Paul Bassewitz*, censor; *Dr. Paul Mason*, delegate; and *Dr. Fred Nause*, alternate delegate.

This meeting's program also included a discussion of the composite averages of overhead expenses for a large number of Midwest doctors by Don Smith, Appleton. Mr. Smith, who is affiliated with a professional management organization, also suggested ways in which changes could be made to improve the net gain.

Trempealeau–Jackson–Buffalo

The Krohn Clinic and Hospital at Black River Falls was host on October 22 to members of the Trempealeau–Jackson–Buffalo County Medical Society. A banquet at the Hotel Freeman preceded the meeting, at which the guest speakers were two Madison physicians, Drs. Nathan Smith, professor and chairman of the department of pediatrics, and David Smith, instructor in pediatrics, University of Wisconsin Medical School. (According to a clipping received from the *Black River Falls Banner–Journal*, the Doctors Smith also had very successful fishing. They caught a ten and a half pound walleye that an official of the Conservation Department believed was the heaviest walleye caught in the Black River in 1957.)

Meeting at the Club Midway on November 26, the society elected *Dr. D. S. Sharp*, Mondovi, president; *Dr. E. P. Rohde*, Galesville, president-elect;

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Dr. Robert MacCornack, Jr., Whitehall, secretary–treasurer; *Dr. B. C. Dockendorff*, Arcadia, delegate; Doctor Rohde, alternate delegate; *Dr. S. W. Simonson*, Whitehall, censor for a term of three years; and *Dr. C. F. Meyer*, Mondovi, censor for a term of one year. A resolution was also passed opposing the expansion of social security benefits as proposed in H.R. 9467, commonly known as the Forand bill.

Vernon

Dr. Robert Samp, Madison, was the guest speaker for the scientific portion of the Vernon County Medical Society's October 23 meeting. Addressing the membership at St. Joseph's Memorial Hospital in Hillsboro, the doctor discussed "Forty-five Ways of Detecting and Preventing Cancer." Doctor Samp is at the tumor clinic at University Hospitals. The eleven members present also heard a talk by Mr. Robert Randall of the staff of the State Medical Society on various features of the Blue Shield plan.

Walworth

The Colonial Hotel in Delavan was the site of the November 14 meeting of the Walworth County Medical Society. A Milwaukee physician, *Dr. Bruce Brewer*, presented a paper on "Pediatric Orthopedics." During the business meeting, a nominating committee was appointed to select a slate of officers for 1958.

Washington–Ozaukee

At the annual meeting of the Washington–Ozaukee County Medical Society held on November 21, the following members were elected to office: president, *Dr. John F. Walsh*, Port Washington; president–elect, *Dr. Henry J. Katz*, Cedarburg; secretary–treasurer, *Dr. V. V. Quandt*, Hartford; delegate, *Dr. P. B. Blanchard*, Cedarburg; alternate delegate, *Dr. W. A. Nielsen*, West Bend; censor (one-year term), *Dr. M. E. Monroe*, Hartford; censor (two-year term), *Dr. F. I. Bush*, West Bend; and censor (three-year term), *Dr. K. F. Pelant*, Grafton.

The society recently paid tribute to *Dr. K. T. Bauer*, West Bend, when it held a party in his honor at the Republican House, Kewaskum. The occasion was in commemoration of his fiftieth anniversary as a physician. *Dr. A. T. Grundahl* of West Bend, who was president of the society at the time, presented a gift to Doctor Bauer on behalf of the group.

Winnebago

Winnebago County Medical Society members met on November 14 at the Menasha Elks Club for their regularly scheduled monthly meeting. The program, under the direction of *Dr. Allan Talbot*, Neenah, featured a talk by Dr. Ralph Suechting, Neenah.

Dr. Paul S. Emrich, Oshkosh, was elected president of the society when it met on December 5 at the American Legion Clubhouse in Oshkosh. Other officers to serve with him include *Dr. George P. Schwei*, Menasha, president-elect and vice president; *Dr. George B. Hildebrand*, Menasha, secretary–treasurer; Doctor Schwei and *Dr. Ernest A. Strakosch*, Oshkosh, delegates; and *Dr. Warren V. Hahn*, Oshkosh, and *Dr. David M. Regan*, Neenah, alternates.

The speaker for the scientific part of this program was Dr. Leslie Stone, Oshkosh, who presented a paper on circulatory disorders of the legs and feet.

Milwaukee Academy of Medicine

A meeting of the Milwaukee Academy of Medicine was held on November 19 at the University Club of Milwaukee. The guest speaker was Dr. David P. Earle, professor of medicine, Northwestern University Medical School. He discussed "Glomerulonephritis."

The academy met on December 17 to hear an address by Dr. John P. Merrill of the Harvard Medical School. "The Problem of Tissue Transplantation—Experiences with the Human Kidney" was the title of his paper.

Milwaukee Neuro-Psychiatric Society

On November 20, the Milwaukee Neuro-Psychiatric Society members were entertained on the occasion of their monthly meeting by the Milwaukee Sanitarium Foundation. The society had as guests the members of the Milwaukee County Psychological Association. The sponsorship of this program is an annual one and is part of Milwaukee Sanitarium Foundation's educational program designed to be of interest to the medical profession.

A special feature of the meeting was a paper on "A Recorded Fragment of Psychotherapy with Discussion," presented by Dr. Carl R. Rogers of the departments of psychology and psychiatry, University of Wisconsin.

Milwaukee Oto-Ophthalmic Society

The guest speaker for the November 29 meeting of the Milwaukee Oto-Ophthalmic Society was Dr. Frank W. Newell, Chicago. A professor of ophthalmological surgery and chairman of the section of ophthalmology at the University of Chicago, the doctor discussed "Complications of Glaucoma Surgery Leading to Enucleation."

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So declared the Blue Shield Commission in a recent policy statement. The Commission is the elected board of directors of the national association, Blue Shield Medical Care Plans, Inc., whose members are the 70-odd medical society-sponsored, nonprofit Blue Shield plans.

The medical profession, through its own instrument, Blue Shield, pioneered the great uncharted realm of medical prepayment at a time when most commercial insurance companies declared it was actuarially impossible, and when the bureaucrats in Washington asserted that only big government could do the job.

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The first requirement of a medical prepayment plan that wants to call itself Blue Shield is that it be approved by the county or state society in the area that it serves. The second requirement is that all medical policies and operations be under medical control, and the third, that it earn the voluntary participation of at least a majority of the doctors in its territory.

Blue Shield is not a "third party." In truth, Blue Shield has proved that doctors and patients, working together, can solve the problems of medical economics without needing any third party to come between them.—*Blue Shield Medical Care Plans, Inc., January, 1958.*

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OBITUARIES

Dr. A. L. Herron, Milwaukee, passed away September 27 at the age of 92.

A medical degree from Howard University, Washington, D. C., was received by Doctor Herron in 1896. He was a gynecologist in Milwaukee for 55 years and was formerly a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by a daughter, Mrs. Lucille Montgomery, Chicago, Illinois.

Dr. C. F. Hardy, a general practitioner in Milwaukee for 50 years, died November 1 after a long illness. He was 89 years of age.

He was born in 1868 at Genesee, attended the old Carroll Academy (now Carroll College), and received a degree in modern classics from the University of Wisconsin in 1891. Before entering medical school at Johns Hopkins University, he served as principal of East Troy High School for four years. He graduated from medical school in 1902 and interned at Mercy Hospital, Pittsburgh, Pennsylvania. While practicing in Milwaukee, Doctor Hardy was on the staffs of St. Mary's Hospital, Milwaukee Orphans' Asylum, Milwaukee Protestant Home for the Aged, and the Martha Washington Home.

Until the time of his retirement in 1952, Doctor Hardy was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

His wife, Mary Belle, and a daughter survive.

Dr. Michael A. Santilli, 51, of Milwaukee, died November 2 after a two-year illness.

Born in 1905 in Italy, Doctor Santilli came to the United States at the age of 5. He graduated from the University of Wisconsin in 1926 with a degree in pharmacy and worked in Milwaukee in that field until 1946, the year he received a medical degree from Marquette University School of Medicine. From 1947 to 1948 he interned at St. Mary's Hospital in Milwaukee. He opened a general practice in Milwaukee and also practiced on a part-time basis with

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the U.S. Public Health Service. Ill health forced him into retirement in 1955.

Doctor Santilli was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include his wife, Natalie; four sons, Denis, Robert, Ronald, and Daryl; and a daughter, Susan, all of Milwaukee.

Dr. E. A. MacCornack, formerly of Whitehall, died December 8 in Boulder, Colorado. He was 71 years of age.

He was born in 1886 in Illinois and graduated from the University of Illinois College of Medicine in 1913. Following an internship at Englewood Hospital, Chicago, he opened his first practice at Whitehall. As a result of Doctor MacCornack's suggestions, the Whitehall Community Hospital was built, and he became superintendent of the hospital when it opened in 1917. Within the next two years he, together with his brother, Dr. R. L. MacCornack, and Dr. F. S. Simons, organized the MacCornack Clinic in the community. In 1923 he went into the field of medical missionary work, serving as superintendent and surgeon-in-chief of the British American Hospital near Lima, Peru. During the 20 years he spent in Peru, Doctor MacCornack founded the Medical Society of Peru, was mayor of Bellavista for a number of years, and served as private physician to the president of Peru. In 1943 he returned to the United States and served in Nevada and Virginia. He came back to Whitehall for a brief period before retiring in 1956.

Doctor MacCornack was a former member of the Trempealeau–Jackson–Buffalo County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. He was a Fellow of the American College of Surgeons.

Survivors include his wife, a son, two granddaughters, two sisters, and three brothers.

Dr. Benn P. Churchill, an ophthalmologist in Milwaukee for several years, expired November 5 at the age of 92.

Doctor Churchill was born in 1865 at Uxbridge, Ontario, and graduated from Trinity Medical College, Toronto, in 1897. Before taking a residency in ophthalmology at Rush Medical College in Chicago, he practiced as a country doctor in Oneida County. In 1904 Doctor Churchill located in Milwaukee,

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where he practiced until his retirement in 1930, after which time he spent a great deal of time with his hobby of astronomy.

Formerly, he was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, the American Medical Association, and the American Association for the Advancement of Science.

A son and two daughters survive Doctor Churchill.

Dr. W. J. Voellings, a practicing physician in Mukwonago for over 30 years, died November 11. He was 60 years of age.

A native of Wisconsin, having been born in Milwaukee in 1897, he graduated from Marquette University School of Medicine in 1928. After interning at St. Mary's Hospital, Milwaukee, Doctor Voellings began a practice in that city and remained until 1935, when he moved to Mukwonago. He was a veteran of World War I.

Memberships were held by him in the Waukesha County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Doctor Voellings is survived by his wife, Alma; a son, William J.; a brother; and four sisters.

Dr. Hattie L. Wilkerson died November 11 in Crivitz. She was 97 years of age.

She was born in 1860 at Burnettsville, Indiana, in White County, where she spent most of her life. In 1891 she was graduated from the Curtis Physio-Medical Institute at Marion, Indiana, and she was a practicing physician in Monticello, Indiana, for 37 years. She had been residing in Wisconsin since 1946.

Dr. John A. Schindler, 54, died November 16 in an automobile accident while enroute to his home after a house call.

He was born in New Glarus in 1903. He received his Bachelor of Science and Master of Science degrees at the University of Wisconsin and was an instructor for two years in the University's bacteriology department. In 1931 he graduated from Washington University School of Medicine, St. Louis, Missouri, and he interned in University Hospitals in Iowa City. Doctor Schindler opened his first practice in New Glarus in 1932 and relocated in Monroe in 1934, becoming a co-founder of the Monroe Clinic. He was chairman of the department of medicine at the clinic and was certified by the American Board of Internal Medicine in 1937.

In 1955, Doctor Schindler became widely known as an author when his book, *How to Live 365 Days a Year*, was published. His latest work was entitled *Woman's Guide to Better Living*. Earlier in his career he wrote *The Old Lead Trail*, a history of southwestern Wisconsin, which was used as a seventh grade textbook in Monroe's schools.

He was an active participant in the preceptorship plan of the University of Wisconsin Medical School, on the medical staff of the St. Clare Hospital, Mon-

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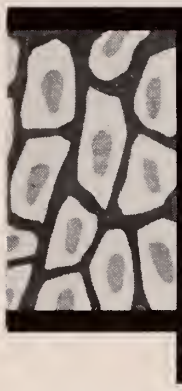

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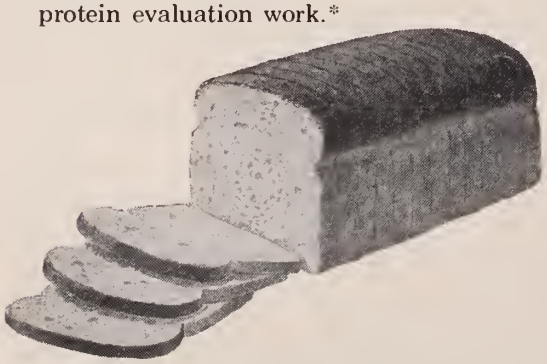

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roe, a member of the State Board of Medical Examiners from 1953 to 1956, chairman of the Division on Geriatrics of the Commission on State Departments, and examiner for several insurance companies.

At the time of his death, Doctor Schindler was a member of the Green County Medical Society, the State Medical Society of Wisconsin, the American Medical Association, the American Heart Association, the Wisconsin Heart Association, and the American Trudeau Society. He was an Associate in the American Geriatrics Society and a Fellow in the American College of Physicians and the American College of Chest Physicians.

Surviving with his wife, Dorothea, are three daughters, Mrs. Carol Brand, Elsa, and Dora, of Madison; a son, John, Jr.; and a grandson.

Dr. W. C. Verbrick, Little Chute, died unexpectedly November 19. He was 56 years of age.

Doctor Verbrick was born in 1901 at Appleton. Prior to entering Marquette University School of Medicine, from which he graduated in 1928, he studied at the University of Wisconsin. He interned at Milwaukee County Hospital. Doctor Verbrick began his medical practice at Wayside and in 1934 moved to Keshena, where he remained until 1941. He next located in Little Chute and left about two years ago to obtain specialty training in anesthesiology at the University of Minnesota. Upon completion of his residency, he became associated with St. Agnes Hospital, Fond du Lac. Three weeks before his death he had accepted a staff position at Central State Hospital, Waupun.

Doctor Verbrick was a member of the Outagamie County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his widow, three sons, and a daughter.

Dr. L. L. Weissmiller, a former Wisconsin physician, died unexpectedly December 7 in Massachusetts. He was 54 years of age.

Born in 1903 in Washington Township, Doctor Weissmiller graduated from the University of Wisconsin Medical School in 1930 and interned at Wisconsin General Hospital. During his career, he practiced in Albany for four years; served five years with the National Guard during World War II, spending 23 months in the Caribbean area and being stationed as executive officer at the Veterans Administration Hospital in Butler, Pennsylvania; was assistant superintendent of Wisconsin General Hospital for five years; headed the Ochsner Foundation in New Orleans, Louisiana; and, since last March, was superintendent of the Veterans Administration Hospital at Rutland, Massachusetts.

Previous memberships included the Dane County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his wife, Frances, and a daughter, Judith.

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News Items and Personals*

Doctor Bauer Honored

Dr. K. T. Bauer of West Bend was honored at a party given by the Washington–Ozaukee County Medical Society at the Republican House in Kewaskum in commemoration of his completion of 50 years of practice.

Although he was born and grew up in Milwaukee, his first six years of practice after graduation from the old Marquette Medical School in 1907 were spent at Beechwood in Sheboygan County, as a "country doctor" of the horse and buggy style. He then moved to West Bend, where he has remained except for periods of postgraduate study at Harvard and at Denver University; in Indiana, Cleveland, and Chicago; and at the University of Vienna in Austria.

Doctor Bauer is still practicing on a small scale to serve some of his old-time patients.

Doctor Byrne Opens Practice in Amery

Dr. William Byrne opened his first private practice in November at the Cornwall Clinic in Amery.

A native of North Dakota, Doctor Byrne earned his B.S. degree at the University of North Dakota. He received his medical degree from Harvard Medical School and interned at St. Luke's Hospital in Duluth. He served two years as a flight surgeon with the U. S. Air Force.

Doctor Beno Opens Office in Green Bay

Dr. T. J. Beno has announced the opening of his office in the Minahan Building in Green Bay, where he will be associated with *Dr. Fabian Gosin.*

A native of Green Bay, Doctor Beno was graduated from St. Norbert College in 1943 with a B.A. degree in chemistry and was graduated from the University of Wisconsin Medical School in 1946. He interned at St. Joseph's Hospital in Marshfield. Doctor Beno received special postgraduate training in general and thoracic surgery and while a surgical resident was given the Gramling Award for scientific writing by the Medical Society of Milwaukee County.

For the past three years he has been in private practice in general and thoracic surgery with the Muncie Clinic in Muncie, Indiana.

* Physicians whose names are printed in italics are members of the Society.

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Dr. Spencer Beebe Honored on 88th Birthday

In November, *Dr. Spencer Beebe*, Sparta, one of Wisconsin's oldest practicing physicians, observed his 88th birthday.

His son, *Dr. Dewitt Beebe* entertained the Sparta Clinic staff at a dinner at the Sidney Hotel, and a family dinner held in the evening commemorated the occasion. St. Mary's Hospital feted the doctor with a birthday party, and he was honored at the November birthday party at the Monroe County Infirmary. Doctor Beebe still makes daily visits to both hospitals.

Doctor Beebe was born and raised in Sparta. He received his medical degree from Rush Medical College in 1896. His first five years of practice were in Elroy, and then he moved to Sparta.

He has become widely known for his leadership in civic activities and has served in various capacities with the State Medical Society throughout his years of affiliation. He is a life member of the Society.

Dr. Hudek Completes 30 Years of Practice in Bloomer

In December, *Dr. D. F. Hudek* began his thirty-first year of practice in Bloomer. He came there in 1927 from Princeton, where he had begun his first practice in 1919.

After graduation from Marquette University School of Medicine, Doctor Hudek served his internship at Milwaukee County Hospital. Then he practiced at the Lying-in Hospital, Chicago, after which he spent six months as a resident physician at the state tuberculosis sanatorium at Wales before going into the Army for a 22-month period. He returned to Lying-in Hospital after his discharge and served as resident physician there before moving to Princeton.

A testimonial dinner in Doctor Hudek's honor is being arranged by the Bloomer Chamber of Commerce.

Dr. Evensen Head of Manitowoc Guidance Center

Dr. Norman A. Evensen, Sheboygan, has been appointed director of the Manitowoc Child Guidance Center. Doctor Evensen recently joined the Sheboygan Clinic as a psychiatrist. He will serve the center on a part-time basis under the jurisdiction of the Manitowoc County Public Welfare Department.

The purpose of the center is to provide psychiatric evaluation and treatment and to furnish community education in mental health. It serves children of all age groups and any adults connected with children's problems.

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Before coming to Sheboygan, Doctor Evensen was on the staff of the Winnebago State Hospital, where he was in charge of active treatment wards, electro-shock therapy, and insulin treatments.

Doctor Joseph Begins Practice

In October it was announced that Dr. Leo G. Joseph, an internist, has associated with *Dr. F. W. Ernst* of La Crosse.

After graduating from the University of Wisconsin Medical School in 1954, Doctor Joseph served an internship at St. Francis Hospital, La Crosse. He completed a residency at the Veterans Administration Hospital, Iowa City, Iowa, prior to locating in La Crosse.

Dr. N. W. Erickson Moves to Beaver Dam

Dr. Norman W. Erickson has been associated with the Hoyer Clinic in Beaver Dam since January 1. He had previously been practicing in Juneau, where he took over the practice of *Dr. H. J. Heath* in March, 1954.

Doctor Niebauer Has New Office

A move into new office quarters was completed in October by *Dr. Walter E. Niebauer* of Phillips. The eight-room building, constructed of concrete blocks with brick facing, consists of a waiting room, office, doctor's office, two treatment rooms, x-ray room, laboratory, and utility room.

Cerebral Palsy Clinic Held in Wausau

A United Cerebral Palsy seminar was held in Wausau on October 24. Attending the session were physicians, therapists, nurses, parents of palsied children, and others interested in the condition. *Dr. Albert A. Lorenz* of Eau Claire, chairman of the medical-professional advisory board of United Cerebral Palsy of Chippewa Valley, was one of the speakers who addressed the group.

Pediatrician Added to Marshfield Clinic Staff

Dr. George G. Griese joined the Marshfield Clinic staff in October, raising the staff number to 32. Doctor Griese graduated from Western Reserve University School of Medicine in 1951, interned at the Philadelphia General Hospital, and took a pediatrics residency at St. Christopher's Hospital for Children in Philadelphia from 1952 to 1954. An additional year was spent at that hospital under a fellowship in pediatric cardiology sponsored by the Pennsylvania Heart Association. Before moving to Marshfield, Doctor Griese was practicing in Philadelphia.

Appleton Hospital Elects Officers

On December 17, the staff of the St. Elizabeth Hospital, Appleton, held its annual election of

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officers. *Dr. F. J. Rankin* will serve as president, *Dr. W. A. Adrians* was elected vice-president, and *Dr. W. H. Hale* was chosen for the post of secretary. During the dinner meeting *Dr. George T. Hegner* was presented with a certificate of merit for 36 years of service on the executive committee of the St. Elizabeth Hospital medical staff.

Doctor Donohue Retires

Dr. W. E. Donohue, who for the past 45 years has practiced medicine and surgery in Manitowoc, retired in December. The pioneer doctor began practice in Manitowoc after graduating from Northwestern University Medical School in 1910 and completing an internship in Chicago. During World War I he served as a medical officer in France.

Doctor Donohue has served as president of the Manitowoc County Medical Society and as president of the staff of Holy Family Hospital, Manitowoc. He is a Fellow of the American College of Surgeons.

Doctor Erickson Opens Practice

A 1954 graduate of the University of Wisconsin Medical School, *Dr. M. R. Erickson*, has begun medical practice in Green Bay. He interned at the Sacramento Hospital, Sacramento, California. He had two years of service in the U. S. Air Force prior to locating in Green Bay.

Hospital Staff Officers Elected at Clintonville

Dr. H. S. Caskey was recently elected president of the Clintonville Community Hospital staff. Others elected were *Dr. W. J. Boulet*, vice-president, and *Dr. C. A. Topp*, secretary-treasurer. All these physicians are from Clintonville.

Doctor Halberg Has New Quarters

Dr. A. C. Halberg moved into new quarters in the Turtle Lake Municipal Office Building in early November. The doctor's office is on the ground floor of the building.

Dr. Welbourne Cancer Board Chairman

At the annual meeting of the Wisconsin Division of the American Cancer Society held in November, *Dr. R. P. Welbourne*, Watertown, was elected chairman of the board of directors.

Other physicians named to offices include *Dr. R. C. Frank*, Eau Claire, first vice-president; *Dr. P. B. Blanchard*, Cedarburg, chairman of the executive committee; and *Dr. Paul Cunningham*, Appleton, new member of the board.

Fond du Lac Hospital Staff Installs Officers

At the annual meeting of the St. Agnes Hospital staff, Fond du Lac, on January 2, *Dr. D. J. Twohig*,

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Jr., was installed as chief of staff for the coming year. Others to take office were *Drs. E. H. Pawsat*, secretary, *L. J. Keenan*, chairman of the executive committee, and *S. A. Theisen*, member of the executive committee.

Doctor Hutter Gives Speech on Helping Aged

A program designed to stress the importance of caring for the aged was held at St. Agnes Hospital in Fond du Lac on November 13. Principal lecturer at the meeting attended by nurses, representatives of welfare agencies and civic organizations was *Dr. A. M. Hutter*, Fond du Lac. He emphasized that "Our senior citizens should have dignity and esteem and that is where all of us can help." In his talk, Doctor Hutter said that in attempting to help the aged it is necessary to treat the whole individual, with recreation, religion, and discipline. Doctor Hutter is chairman of the Division on Geriatrics of the Commission on State Departments.

THIRD AND TWELFTH DISTRICTS NEWS

Doctor Foseid ACS Fellow

During the month of October, *Dr. Oscar F. Foseid*, Madison, and his family took an eastern vacation trip. Highlight of the trip was Doctor Foseid's admission to the American College of Surgeons as a fellow in a formal graduation ceremony in Atlantic City, New Jersey.

Madison General Staff Names Officers

Officers elected on November 26 by the medical staff of Madison General Hospital are: *Drs. E. J. Nordby*, chief; *Theodore Nereim*, vice-president; *Norman Clausen*, secretary–treasurer; and *Palmer Kundert*, representative to the Dane County Medical Society Board of Trustees.

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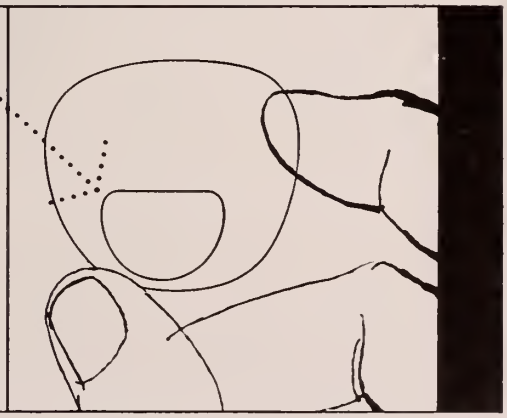

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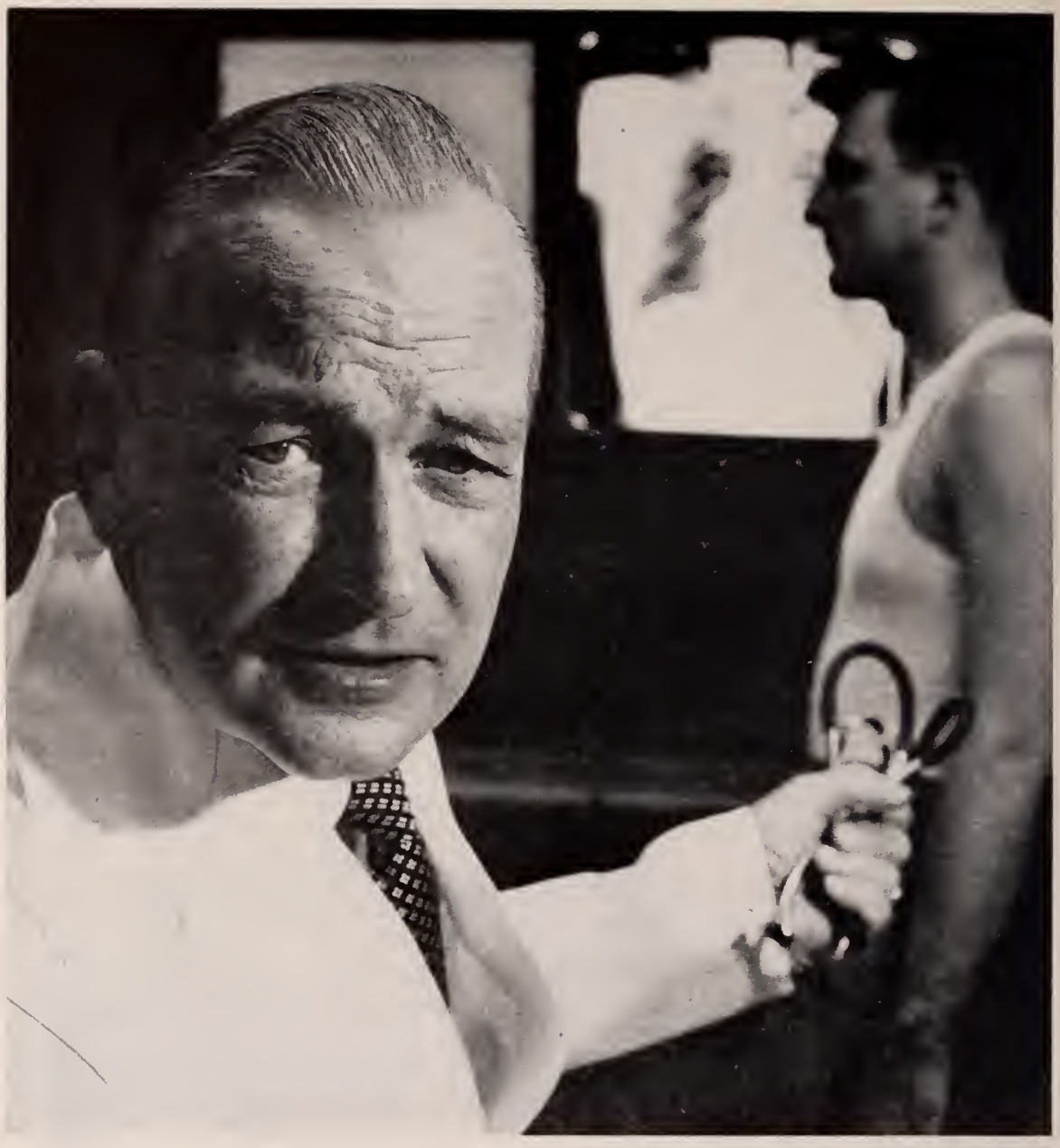

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Dr. Donald Britton—Obstetrics and Gynecology
Dr. R. J. Hennen—General Practice
Dr. William Ylitalo—Pediatrics
Dr. A. J. Richtsmeier—Medicine
Dr. Russell Sinaiko—Surgery

Dr. Zach Addresses P.T.A.

Dr. R. G. Zach, Monroe, was the speaker at a P.T.A. meeting in Brooklyn, Wisconsin, on October 24.

He was one of eight civilian physicians to attend a course in "Mass Atomic Casualties" at Walter Reed Hospital, Washington, D. C., earlier in the year. One of eleven especially invited guests of the Atomic Energy Commission, Doctor Zach toured the secret atom test near Las Vegas, Nevada, and viewed an atomic blast in July.

Doctor Kasak Addresses Women's Group

A talk on mental diseases was given by *Dr. Michael Kasak* at a meeting of the Milwaukee section of the National Council of Jewish Women on November 12. Doctor Kasak, a Milwaukee psychiatrist, was medical director of the county hospital for mental diseases until he retired in 1956 and is emeritus clinical professor of psychiatry at Marquette University School of Medicine.

Doctor Orth Talks in Mexico

Dr. O. S. Orth, chairman of the department of anesthesiology at the University of Wisconsin Medical School, was the guest speaker at the November meeting of the First Mexican Congress of Anesthesiologists at the University of Guadalajara, Mexico. He chose "The First 25 Years of Clinical Usage of Cyclopropane at Wisconsin" as the subject of his talk.

Doctor Dickie on TB Board

Dr. Helen A. Dickie, professor of medicine, University of Wisconsin Medical School, has been named to complete the term of *Dr. Richard P. Jahn*, Milwaukee, on the board of directors of the Wisconsin Anti-Tuberculosis Association. Doctor Jahn will join the staff of the association's medical department.

Doctor Dickie was certified in 1945 by the American Board of Internal Medicine and in 1946 in the subspecialty of tuberculosis. She is president of the Wisconsin Trudeau Society.

P.T.A. Hears Doctor O'Connor

A talk was presented on November 7 by *Dr. Robert E. O'Connor*, Madison, to the Edgewood Campus School Parent–Teacher Association. Doctor O'Connor is clinical professor of psychiatry at the University of Wisconsin and chief of the children's service at the Wisconsin Diagnostic Center.

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Dr. Tenney Named Head of Youth Council

Governor Thomson recently named *Dr. H. Kent Tenny*, Madison pediatrician, to direct the Wisconsin Council on Youth Fitness. This newly organized group is designed to improve existing programs in the state which promote physicial fitness.

Doctor Cahana Honored

Dr. Stephen Cahana was presented a certificate of appreciation for service rendered Marquette University on September 23. The presentation was made at a dinner in the Pere Marquette Room of Brooks Memorial Union.

The certificate, signed by the Very Rev. E. J. O'Donnell, S.J., president of the university, reads as follows:

"The President and Trustees of Marquette University, Milwaukee, Wisconsin, are happy to present to Dr. Stephen Cahana this certificate of appreciation for his many years of devoted service and constant support and encouragement of Marquette University's aims and ideals."

Marquette Receives NFIP Grant for Study on ECHO 9 Virus

The National Foundation for Infantile Paralysis has awarded Marquette University School of Medicine a grant of $36,846 to continue its investigation of the effect of ECHO 9 virus on pregnancy and the unborn infant. During the period from May 15 to September 15, 1957, about one of every ten pregnant women in the Milwaukee community (about 1,600) was infected by ECHO 9. In late September the NFIP granted an emergency appropriation to study the epidemic. The grant just received will continue this work.

Dr. John C. Peterson, professor of pediatrics at Marquette, will direct the study, assisted by *Dr. Lucille Glicklich*, clinical instructor in pediatrics, and several public health nurses.

In commenting on the grant, Doctor Peterson stated, "This study affords Milwaukee a unique opportunity. ECHO 9 occurred in this community with strong epidemic force at a time when there were no other prevalent infections. Serologic tests and a study of the infection itself would give us much valuable information."

The study will be carried on for at least a year and nine months to afford the research group the opportunity to locate women who were pregnant during the epidemic period and to study the babies for at least a year after birth to see that they grow and develop in a normal way.

Dean Bowers Speaks in Neenah

Dr. John Z. Bowers, dean of the University of Wisconsin Medical School, spoke to the Women's Tuesday Club of Neenah on November 12. His topic was "Modern Medicine."

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UW Medical School Faculty Attend Meetings

Included among meetings attended by University of Wisconsin Medical School faculty members in October and November are: American Roentgen Ray Society, Washington, D. C., in October—*Dr. L. W. Paul;* Association of American Colleges, Atlantic City, New Jersey, in October—*Drs. J. Z. Bowers,* dean, who attended as a member of the Executive Council and as the official representative of the UW Medical School, *Dr. Ben Peckham,* obstetrics-gynecology, who participated in the deliberations on the selection and progress of medical students, and Dr. Harold Rusch, oncology; meeting of coordinators of cancer teaching and scientific meetings of the American Cancer Society, New York City, in October—*Dr. F. J. Ansfield;* Trauma Conference, Hot Springs, Virginia, October 30–November 2, *Dr. K. E. Lemmer;* American Federation for Clinical Research and Central Society for Clinical Research, Chicago, in October—Drs. D. T. Graham, *R. F. Schilling, S. B. Crepea, G. G. Rowe, D. H. White,* G. M. Maxwell, J. Rankin, *A. P. Crosley, Jr., C. W. Crumpton,* Nathan Smith, *O. O. Meyer,* and H. Waisman.

Doctor Angevine on Cancer Society Committee

Dr. D. Murray Angevine, professor and chairman of the department of pathology at the University of Wisconsin Medical School, has accepted an appointment to serve on an American Cancer Society advisory committee. He has been appointed to the Committee on Research on Pathogenesis of Cancer.

"Ladies Day Out" for Asian Flu Discussion

Dr. Marshall Purdy of Janesville was asked by the city's Y.W.C.A. to talk on Asian flu on October 23. He spoke to the third session of the "Ladies Day Out" group on the historical background of the disease, incidence of the epidemic in this country as it affects various social and economic aspects of life, effectiveness and availability of vaccine, and attack rate of the disease.

Last year he addressed the "Ladies Day Out" group on "The Birth of a Child—Human Beginnings and Human Reproduction."

Dr. Bernard Presents Talk

Dr. Frank Bernard, associate clinical professor of surgery, University of Wisconsin Medical School, presented a paper on "Derma-Tattooing: Preliminary Report" during the annual meeting of the American Society of Plastic and Reconstructive Surgery, November 3–8. The meeting was held in San Francisco.

West Allis Names Dr. Bertolaet Health Commissioner

Dr. Elmer E. Bertolaet, who has been Kenosha's director of health for the past five years, has been appointed health commissioner for West Allis to

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SURGERY—Surgical Technic, Two Weeks, March 24, April 21, May 12
Surgery of Colon and Rectum, One Week, April 7
Basic Principles in General Surgery, Two Weeks, April 7
Treatment of Varicose Veins, April 7, May 5
Gallbladder Surgery, Three Days, March 31
Surgery of Hernia, Three Days, April 3
General Surgery, Two Weeks, May 5; One Week, May 12
Fractures & Traumatic Surgery, Two Weeks, March 17
Breast & Thyroid Surgery, One Week, May 5

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, Two Weeks, March 17
Vaginal Approach to Pelvic Surgery, One Week, April 28
General & Surgical Obstetrics, Two Weeks, March 31

MEDICINE—General Review Course, Two Weeks, May 12
Electrocardiography & Heart Disease, Two Weeks, March 17
Hematology, One Week, June 2
Gastroenterology, Two Weeks, April 14

PEDIATRICS—Two-Week Intensive Course, April 21

DERMATOLOGY—Clinical & Didactic Course, Two Weeks, May 5

RADIOLOGY—Diagnostic X-Ray, Two Weeks, April 28
Clinical Uses of Radioisotopes, Two Weeks, May 5

UROLOGY—Two-Week Intensive Course, April 14
Cystoscopy, Ten-Day Practical Course, by appointment.

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succeed *Dr. E. V. Brumbaugh*, who retired January 1. Doctor Bertolaet assumed his new position February 1.

He was graduated from the University of Wisconsin Medical School and earned a master's degree in public health at the University of Minnesota in Minneapolis. He spent 14 years in private practice. He was a district administrator for the State Board of Health for six years, serving as director of its largest district, which included Kenosha, Racine, and Milwaukee counties.

Doctor Bertolaet was the first health director in Kenosha with training and experience in the public health field and, during his administration there, several innovations in public health were made.

MARRIAGES

Dr. Lilliam M. Thomas to *Dr. George R. Wagner*, both of Milwaukee, on January 18.

SOCIETY RECORDS

New Members

J. P. Sauer, 211 Water Street, Stevens Point.
G. F. Armstrong, 625 57 Street, Kenosha.
D. B. Horsley, 522 56 Street, Kenosha.
G. F. Pratt, 1020 Kabel Avenue, Rhinelander.
T. J. Beno,* 205 East Walnut Street, Green Bay.
D. F. Barcome, Gillett.
Paul Natvig, 324 East Wisconsin Avenue, Milwaukee.
H. W. Strass, 759 North Milwaukee Street, Milwaukee.
L. J. Enders,** 1420 North Eighth Street, Milwaukee.
W. F. Kennedy,** Quarters 2546A, Fort Lewis, Washington.
A. M. Kowalski,** 4310 North 44 Street, Milwaukee.
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C. L. Blahnik, 600 Oconto Avenue, Peshtigo.
C. A. Gehring, 1700 North Main Street, Racine.
C. W. Docter, 1137 Park Avenue, Racine.
R. A. Holland, 500 West Milwaukee Street, Janesville.
R. A. Berk, 1628 West Wisconsin Avenue, Milwaukee.
R. L. Beilman, 113 North Carroll Street, Madison.
J. W. Beattie, Lake Geneva.
R. B. Windsor, The Sheboygan Clinic, Sheboygan.
W. W. Grover, Jr., Box 522, Bonduel.
R. D. Waldorf, 205 West Milwaukee, Janesville.
C. F. Melchor, Jr., Medical Arts Building, Wausau.
J. D. Kramer, 808 Third Street, Wausau.
J. W. Stackpole, 501 Jefferson Street, Wausau.
L. L. Schloesser, 650 South Central Avenue, Marshfield.
J. H. Lodge, 1300 University Avenue, Madison.
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WANTED TO BUY: Pediatric examining table in good condition. Address replies to Box 710 in care of the Journal.

WANTED: Psychiatrists or young doctors interested in psychiatry to work at Mendota State Hospital. Positions are permanent and under Civil Service; salary depends upon previous experience and training. Housing available on grounds Contact Dr. W. J. Urben, Superintendent, Madison 4, Wis.

WANTED: Radiologist and pathologist for 50-bed hospital in Milwaukee. Address replies to Box 717 in care of the Journal.

WANTED: House physician for 50-bed hospital in Milwaukee. Address replies to Box 718 in care of the Journal.

WANTED: Registered laboratory technician for 50-bed hospital in Milwaukee. Address replies to Box 719 in care of the Journal.

WANTED: At present very much in need of two physicians to do surgery and general practice in a central Wisconsin community of 5,000 population with 4 industrial plants. Seventy-bed hospital, with up-to-date facilities, services the community. Address replies to Box 721 in care of the Journal.

WANTED: Pediatrician, Board certified or eligible, to join established 16-man clinic in Wisconsin community of 40,000. Address replies to Box 722 in care of the Journal.

WANTED: Full-time and part-time medical consultants for Division of Disability Operations of Bureau of Old-Age and Survivors Insurance, Social Security Administration. Usual Federal Civil Service benefits in the full-time positions. Salary range $10,065 to $11,395. Salary in part-time positions paid on per diem basis. Openings are in Baltimore, Maryland. For further information write Dr. Arthur B. Price, Chief Medical Consultant, Division of Disability Operations, 200 West Baltimore St., Baltimore 1, Maryland.

WANTED: Physician to take over general practice from April 5 to May 7 while regular physician is in Hawaii on vacation. Convenient office with good assistants and excellent hospital facilities. In town on Wolf River. Position available during pike season, and boat and motor will be at physician's disposal if he is a fisherman. Either married or single physician can occupy regular physician's home and use his car if necessary. Address replies to Box 723 in care of the Journal.

GENERAL PRACTITIONER WANTED: Prosperous resort and industrial community in northern Wisconsin needs doctor. Health officer's salary is $1,500 per year in addition to income from private practice. Town furnishes most equipment. Excellent school, 5 churches. Ideal location for young or middle-aged doctor wishing partial retirement. Apply to Mrs. Kathryn I. Taylor, Clerk, Town of Mercer, Wis., for details and interview.

PHYSICIAN WANTED: For lucrative general practice in south central Wisconsin community of 8,000. Excellent hospital facilities. Grossed over $37,000 by audit last year. Complete office equipment for $5,000. Could not duplicate for three times the amount. Will help establish new man. Act now as owner is accepting another position. Real opportunity. Address replies to Box 716 in care of the Journal.

PHYSICIAN WANTED in growing town with population of 1,600, 13 miles from large hospital. Used office equipment and instruments available for reasonable fee. Original office space still available. A large and growing practice possible. Town now has only one doctor. For further information write, Dr. W. J. Voellings Estate, P. O. Box 296, Mukwonago, Wis.

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PHYSICIANS, with or without pediatric training, needed in maternal and child health program at salaries ranging from $8,728 to $10,765. Five-day week, pension, civil service appointment. Address replies to Dr. E. R. Krumbiegel, Milwaukee Health Department, City Hall, Milwaukee, Wis.

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Alternates

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E. L. Bernhart, Milwaukee, 1958
R. E. Galasinski, Milwaukee, 1959
A. A. Quisling, Madison, 1959

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List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland–Bayfield–Iron	H. V. Sandin 220 Seventh W. Ashland	C. A. Grand 522 W. Second Ashland	
Barron–Washburn–Sawyer–Burnett	C. J. Strang Barron	H. M. Templeton Barron	Second Tuesday 7:30 p.m.
Brown	George Nadeau 128 E. Walnut Green Bay	Frank Urban 305 E. Walnut Green Bay	Second Thursday*
Calumet	J. A. Knauf Stockbridge	K. R. Humke Chilton	
Chippewa	B. J. Haines Cadott	R. L. Hendrickson 12 Third Cornell	Second Tuesday
Clark	T. N. Thompson, Jr. Neillsville	H. M. Braswell, Jr. Owen	
Columbia–Marquette–Adams	H. A. Winkler 115 W. Chestnut Pardeeville	T. S. Westcott Pardeeville	Every Third Month 7:00 p.m.
Crawford		H. L. Shapiro Prairie du Chien	Third Wednesday
Dane	T. J. Nereim 3710 Spring Trail Madison	A. P. Schoenenberger 122 W. Washington Madison	Second Tuesday Sept. through June
Dodge	R. F. Boock 119½ Front Beaver Dam	G. G. Drescher 106½ Front Beaver Dam	Last Thursday*
Door–Kewaunee	J. G. Beck Sturgeon Bay	J. F. March 413 4th Algoma	
Douglas	R. T. Anderson 1507 Tower Superior	L. R. Rosin 2231 E. Fifth Superior	First Wednesday** Hotel Superior
Eau Claire–Dunn–Pepin	D. M. Willison 314 E. Grand Eau Claire	K. E. Walter 131 S. Barstow Eau Claire	Last Monday
Fond du Lac	John C. McCullough 20 Forest Fond du Lac	R. W. Schroeder 330 Ledgeview Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley Wabeno	D. V. Moffet Crandon	
Grant	K. L. Bauman Lancaster	H. W. Carey Lancaster	Last Thursday, March, June, Sept. and Nov.
Green	M. W. Stuessy Brodhead	R. G. Zach Monroe Clinic Monroe	
Green Lake–Waushara	G. G. Mueller Princeton	J. C. Koch Berlin	Last Thursday, every other month starting in Jan.
Iowa	C. L. White Mineral Point	E. J. Hohler Mineral Point	First Thursday following first Monday
Jefferson	E. E. Burzynski 113 N. Third Watertown	E. P. Schuh 706 Madison Watertown	Third Thursday*
Juneau	J. H. Vedner Mauston	J. S. Hess Mauston	Second Tuesday Hess Clinic in Mauston

* Except June, July, and August.

** Except July and August.

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Kenosha	W. C. Kleinpell 723 58th Kenosha	Mr. L. F. Jost, Ex. Sec. Box 669 Kenosha	First Thursday* Elks Club
La Crosse	F. J. Gallagher 630 S. Tenth La Crosse	J. B. Durst 1707 Main La Crosse	Third Monday
Lafayette	R. E. Hunter Argyle	N. A. McGreane 123 E. Ann Darlington	Last Tuesday
Langlade	R. W. Cromer 824½ Fifth Antigo	J. E. Garritty Antigo	First Monday
Lincoln	F. C. Lane 401 W. Main Merrill	J. D. Millenbah 121 S. Mill Merrill	
Manitowoc	J. W. Steckbauer Suite 304, Savings Bank Building Manitowoc	R. J. Banker 709 Washington Manitowoc	Last Thursday
Marathon	J. V. Flannery 808 Third Wausau	R. B. Larsen 510½ Third Wausau	
Marinette–Florence	C. H. Boren Marinette	K. G. Pinegar 516 Houston Marinette	Third Wednesday St. Joseph's Hospital
Milwaukee	S. A. Morton 3321 N. Maryland Milwaukee	L. R. Schweiger 324 E. Wisconsin Mr. J. O. Kelley, Ex. Sec. 756 N. Milwaukee Milwaukee	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	H. A. Aageson 1113 Main Oconto	C. E. Siefert Oconto Falls	
Oneida–Vilas	T. M. Haug 1020 Kabel Rhinelander	Marvin Wright 1020 Kabel Rhinelander	Monthly
Outagamie	George A. Behnke 240 W. Wisconsin Kaukauna	George A. French 601 W. College Appleton	Third Thursday* Elks Club
Pierce–St. Croix	G. E. Bourget Hudson	P. H. Gutzler River Falls	Third Tuesday
Polk	Stella I. Burdette Balsam Lake	L. J. Weller Osceola	Third Thursday 7:00 p.m.
Portage	H. A. Anderson River Pines Sanatorium Stevens Point	W. A. Gramowski 319½ Main Stevens Point	
Price–Taylor	E. B. Elvis Medford	J. J. Leahy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
Racine	L. M. Lifsehutz 816 16th Racine	W. H. Williamson 1101 Grand Racine	Third Thursday
Richland	K. H. Meyer Richland Center	L. M. Pippin Richland Center	First Tuesday Richland Hospital
Rock	V. S. Falk 5 W. Rollin Edgerton	E. S. Hartlaub 19 S. Main Janesville	Fourth Tuesday
Rusk	M. L. Whalen Bruce	H. F. Pagel Ladysmith	First Tuesday
Sauk	M. F. Huth 203 Fourth Baraboo	J. J. Rouse Reedsburg	Second Tuesday*
Shawano	L. W. Peterson Shawano	A. J. Sebesta Shawano	Third Tuesday
Sheboygan	J. A. Russell Random Lake	R. M. Senty 1011 N. Eighth Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	D. S. Sharp 140 E. Main Mondovi	Robert MacCornack, Jr. MacCornack Clinic Whitehall	Fourth Tuesday
Vernon	P. T. Bland Westby	R. A. Starr Viroqua	Last Wednesday
Walworth	J. B. Schrock Sharon	W. C. Woods 607 Walworth Delavan	Second Thursday*
Washington–Ozaukee	J. F. Walsh 125 E. Main Port Washington	V. V. Quandt 57 S. Main Hartford	Fourth Thursday
Waukesha	James V. Bolger, Jr. 102 E. Main Waukesha	Philip Wilkinson 618 W. La Belle Oconomowoe	First Wednesday
Waupaca	Owen Larson Clintonville	H. S. Caskey Clintonville	
Winnebago	P. S. Emrich 456 Mt. Vernon Oshkosh	G. B. Hildebrand 216½ Main Menasha	First Thursday
Wood	W. L. Nelson 480 E. Grand Wisconsin Rapids	J. R. Heersma 650 S. Central Marshfield	Four times a year

* Except June, July, and August.

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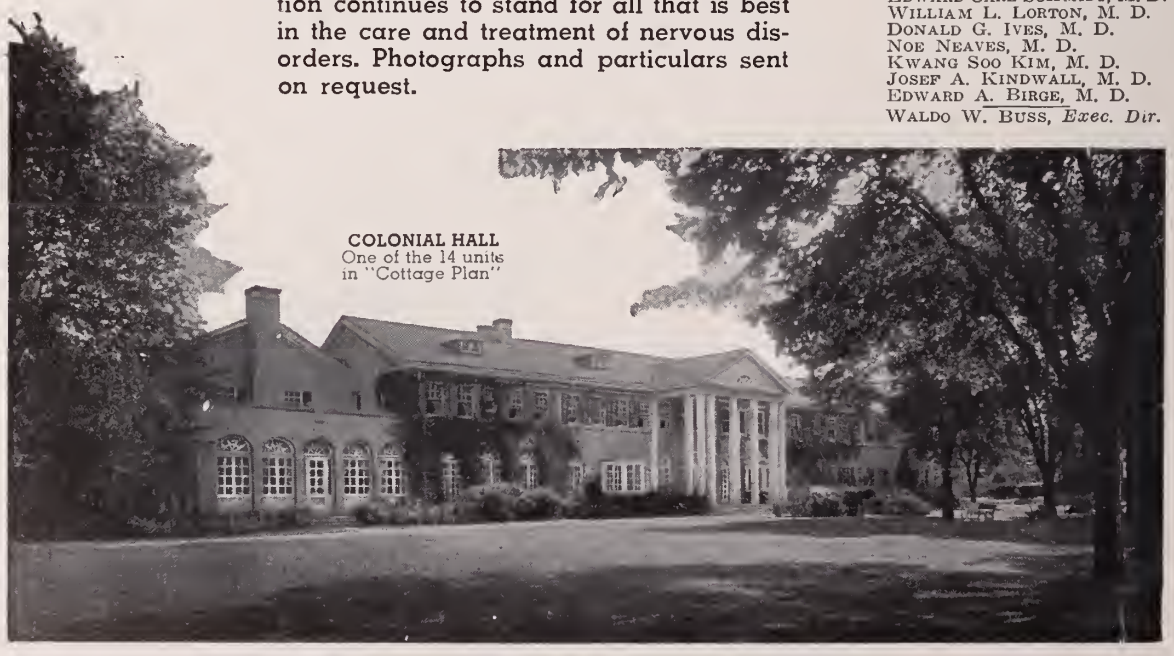

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THE WISCONSIN MEDICAL JOURNAL

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Observations on the Use of Tolbutamide in General Practice

By BERNARD KULKOSKI, M. D., and NORMAN DUCHATEAU, B. S. M. T. (ASCP)
Green Bay

MANY studies by investigators both here and abroad have demonstrated quite satisfactorily that certain aryl-sulfonylurea compounds cause reduction in the blood sugar levels of certain types of diabetics.

This fact has led to an attempt to substitute these substances as an oral replacement for insulin in diabetics. As clinical studies progress and more case studies are made, the fact that the oral substitutes are not a panacea for diabetics becomes evident. Numerous pitfalls, side effects, and failures are encountered and it is necessary that a careful evaluation of patients be made before substitution therapy is attempted.

This study was planned to determine the efficacy of screening known diabetics, either on or off insulin, in a general practice, with the possibility of determining whether they could be successfully transferred to oral therapy while on an ambulatory basis. Tolbutamide (Orinase)* was the compound chosen for this study. No attempt was made to investigate the mode or site of action of the drug.

METHOD

Most patients were known diabetics that had been followed at regular intervals before the study was launched. Most of them were on insulin but a few had refused insulin therapy and several were newly uncovered diabetics. No attempt was made to include only those patients where a satisfactory response based on previous studies would be anticipated.

Patients were thoroughly acquainted with the plan. The need for following all of the previous diets and personal habits was stressed and the experimental problems were discussed freely with the group. Skeptical and noncooperative patients were soon eliminated from the study.

The original plan was to elicit an "Orinase response" on each patient. This was done as follows: The patients ceased taking insulin for two days. On the third morning a fasting blood sugar determination was made and 3 gm. of tolbutamide given. The blood sugar was determined again two and four hours later on the fasting patient. The percentage of fall was then calculated and the patient's ability to transfer to tolbutamide was determined on the basis of this fall. Greater than 25% was considered a satisfactory response.

It soon became evident that the method was unsatisfactory as too many high blood sugar levels were found by the third day and diabetic complications were arising and confusing the "Orinase response" picture. The final method decided upon, one which appears to fit a general practice change-over to tolbutamide, was to have the patient eliminate insulin on the morning of change-over only.

After a fasting blood sugar was determined, 3 gm. of tolbutamide was given and blood sugar levels at two and four hours were recorded. Patients whose blood sugar levels fell to normal after four hours were then instructed to take 1 gm. of tolbutamide each morning for a week. Patients whose blood sugar levels remained between 180 mg.% and 250 mg.% were instructed to take 1.5 gm. of tolbutamide daily, and patients whose blood sugar remained above 250 mg.% were instructed to take 1.0 gm. of tolbutamide plus their usual daily insulin requirement for one week. The patients were then checked

*Tolbutamide supplied as Orinase by Upjohn Company.

weekly. Blood sugar and weight were checked, and complete blood counts, urine analysis, and platelet counts were done. The dose of tolbutamide was then adjusted upward or downward. The rationale of continuing those patients with high blood sugars in the study became evident when a delayed "Orinase response" was found in some, permitting later elimination or diminution of insulin dosage. No untoward reactions were experienced with this method nor was evidence of hypoglycemic shock found. It was felt that it was safer to use a smaller dose of tolbutamide and adjust upward after one week rather than hazard depressing the blood sugar too far during this time.

The study of each patient was followed weekly until either a satisfactory blood sugar level was achieved and maintained with tolbutamide or a combination of tolbutamide and insulin, or until the failures were returned to full insulin therapy.

RESULTS

Twenty-one patients have been studied thus far. Some have been followed for a period of six months or more and are on full maintenance therapy. Others are still in the process of stabilization or have been dropped from the study.

Table 1 is a résumé of the study and results. Complete blood counts and platelet counts were done at all visits and have remained normal.

The only reactions encountered were in patients 4 and 10 (see table 1), in whom a nonthrombocytopenic purpura developed during the third week of therapy. These reactions were controlled with supplementary hesperidin with C therapy and have not recurred. Patient 10 has had a small coronary occlusion and has recovered while on complete tolbutamide coverage.

DISCUSSION

The preceding studies indicate that a screening pattern of known diabetics may be attempted on an ambulatory basis if certain precautions and adequate laboratory studies are followed. The reactions encountered have been minor and patient education has been a great help in preventing complications. It was found that some patients were able to convert completely to tolbutamide, some had no response, and a few were able to reduce their insulin dosage by taking tolbutamide as an adjuvant therapy. Several diabetics had a delayed response to tolbutamide and, with this in mind, all diabetics were carried on tolbutamide for what might appear to be a prolonged period of unsatisfactory diabetic control before maintenance was established. Tolbutamide was considered as an excellent adjuvant therapy in the few brittle diabetics. Most patients experience a marked sense of well-being throughout the day, and present studies are being attempted with blood sugar determinations during the day to see if tolbutamide maintains a more uniform sugar level regardless of eating habits or time of day.

TABLE 1

Age	Age, Onset Diabetes	Weight	Previous Insulin Dose	Present Insulin Dose	Duration Tolbutamide Therapy	Present Tolbutamide Dose	Present Urine Analysis			Fasting Blood Sugar 1st Visit	Fasting Blood Sugar Present	Comment
							Albumin	Sugar	Microscopic			
70	65	155	15u Lente	None	6½ mo.	0.5 gm.	Neg.	Neg.	Neg.	130	120	Excellent
74	64	141	30u PZI	None	6½ mo.	1.5 gm.	Trace	3+	Wbc. 1+	193	236	Good
63	58	135	None	None	6 mo.	1.5 gm.	Neg.	Neg.	Neg.	339	230	Excellent
52	51	139	25u Lente	None	6 mo.	1.0 gm.	Neg.	Neg.	Wbc. 10–15	123	215	Excellent
64	51	174	40u NPH	20u NPH	5 mo.	1.5 gm.	Neg.	Neg.	Neg.	272	261	Good Adjuvant Response
67	63	131	40u Lente	40u Lente	2 mo.	1.5 gm.	Neg.	3+	Neg.	436	128	Good Adjuvant Response
15	14	100	55u Lente	35u Lente	1 mo.	1.0 gm.	Neg.	3+	Neg.	304	378	Failure*
55	47	162	95u Lente	75u Lente	2 mo.	1.0 gm.	Neg.	3+	Wbc. 10–12	363	460	Failure*
10	5	73	34u Lente	34u Lente	4 mo.	1.0 gm.	Neg.	4+	Neg.	430	142	Good Adjuvant Response
52	49	167	35u Lente	None	4 mo.	2.0 gm.	Neg.	2+	Neg.	250	203	Excellent
63	60	112	29u Lente	27u Lente	4 mo.	2.5 gm.	Neg.	Neg.	Neg.	308	166	Good Adjuvant Response
38	34	112	35u Lente	35u Lente	3 mo.	3.0 gm.	Neg.	3+	Neg.	416	318	Failure*
75	67	180	40u PZI	None	4 mo.	2.0 gm.	Trace	1+	Wbc. 4+	100	300	Fair
65	65	175	New diabetic	None	3 mo.	1.0 gm.	Neg.	Neg.	Neg.	256	138	Excellent
74	68	183	25u NPH	None	3 mo.	0.5 gm.	Neg.	Neg.	Wbc. 2–4	128	130	Excellent
70	69	185	33u PZI	None	2 mo.	1.0 gm.	Trace	Neg.	Wbc. 3–5	154	145	Excellent
38	38	207	15u Lente	None	2 mo.	1.0 gm.	Trace	Neg.	Neg.	171	142	Excellent
60	54	187	40u Lente	None	2 mo.	2.0 gm.	Neg.	Neg.	Neg.	112	185	Excellent
69	67	208	New diabetic	None	1 mo.	1.0 gm.	Neg.	Neg.	Neg.	308	166	Excellent
87	87	165	New diabetic	None	1 mo.	1.5 gm.	1+	4+	Neg.	540	226	Excellent
77	77	145	New diabetic	None	1 mo.	1.0 gm.	1+	2+	Many Wbc.	233	203	Excellent

*Failures returned to insulin.

Typical Satisfactory Response

Date	Fasting	2 hr.	4 hr.	Tolbutamide
11/19/56	130	76	82	3 gm.
11/26/56	115			1 gm.
12/ 3/56	93			1.0 gm.
12/10/56	102			1.0 gm.
1/ 7/57	102			1.0 gm.
2/ 4/57	109			1.0 gm.
3/ 4/57	112			1.0 gm.
3/25/57	105			0.5 gm.
4/19/57	120	(postprandial)		0.5 gm.

A 70-year-old woman, known diabetic for five years, moderately obese (155 lbs.) on 15 units Lente insulin. She had resection of the left breast three years ago for adenocarcinoma (Grade 2) and is symptom free at present. She is a school teacher who has been under excellent diabetic control at all times. She was started on tolbutamide six and one-half months ago. She states that she has felt better on tolbutamide and is now running a postprandial blood sugar level within normal limits on 0.5 gm. tolbutamide daily without insulin.

Typical Unsatisfactory Case

Date	Fasting	2 hr.	4 hr.	Tolbutamide	Insulin
12/31/56	304	272	261	3 gm.	None
1/ 7/57	390			1.0 gm.	27u
1/14/57	356			1.0 gm.	35u
1/21/57	378			1.0 gm.	35u

Returned to full insulin therapy

Age 15, known diabetic for one year, asthenic (100 lbs.) maintained satisfactorily on 55u Lente insulin. The patient was started on tolbutamide and study continued for one month without success.

Typical Cases of Successful Adjunct Therapy in Brittle Diabetics

Date	Fasting	2 hr.	4 hr.	Tolbutamide	Insulin
11/24/56	516	478	478	3 gm.	None
1/ 5/57	250			None	40u Lente
3/25/57	436	Post-prandial		None	40u Lente
4/ 1/57	412			1.5 gm.	40u Lente
4/ 8/57	88			1.0 gm.	40u Lente
4/15/57	128			1.5 gm.	40u Lente

Case 1—A woman, aged 67, known diabetic for four years, asthenic (131 lbs.) had diverticulitis with ruptured diverticulum in 1955. She has had recurrent pyelocystitis and diverticulitis necessitating frequent adjustment of insulin dosage. She also has peripheral neuritis and coronary insufficiency. She had one bout of coma four months ago due to pyelocystitis. The patient used to experience frequent insulin reactions when the dose of insulin was raised beyond 40u and various combinations of insulin were not successful. She had no reactions while on the study and has had a marked sense of well-being since.

Date	Fasting	2 hr.	4 hr.	Tolbutamide	Insulin
1/ 9/57	430	430	430	3.0 gm.	None
1/16/57	134			1.0 gm.	34u Lente
1/23/57	436			1.0 gm.	34u Lente
1/30/57	436			1.0 gm.	34u Lente
2/ 6/57	342			1.0 gm.	34u Lente
3/ 7/57	134			1.0 gm.	34u Lente
4/ 3/57	142			1.0 gm.	34u Lente

Case 2—Age 10, known diabetic for five years, weight 73 lbs., uncooperative patient. Coma two years ago. Very brittle. Attempts at regulation by various insulin combinations and varieties unsuccessful. Increasing dose of insulin resulted in frequent insulin reactions. Excellent control under adjuvant therapy.

SUMMARY AND CONCLUSIONS

1. A group of 21 diabetics was studied in an attempt to find an adequate screening device for tolbutamide substitution for insulin on an ambulatory basis.

2. It was demonstrated that by simple elimination of insulin, blood sugar determinations on morning of substitution, then tolbutamide therapy for one week empirically, no untoward side effects were produced, even in those patients not responsive to tolbutamide therapy.

3. Tolbutamide was considered very successful in the older age group, obese diabetics on small insulin dosage.

4. Tolbutamide was considered very successful adjuvant therapy in the several brittle diabetics and in those who encountered frequent infectious diseases where frequent insulin dosage adjustment had been previously required.

5. Two cases of nonthrombocytopenic purpura were encountered. These cases responded to hesperidin with C (Hesper C) and have not recurred.

6. Patient response and cooperation was excellent and patient education was an important factor in the study.

7. No cases of hypoglycemic shock were encountered even when they might have been anticipated.

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414 East Walnut.

MATERNAL MORTALITY INSTITUTES

Two maternal mortality institutes have been held, in Madison and in Milwaukee. Below is the schedule for the remaining two.

WAUSAU, MEMORIAL HOSPITAL
THURSDAY, MARCH 20

EAU CLAIRE, LUTHER HOSPITAL
THURSDAY, MARCH 27

PROGRAM

1:45–5:45 p.m.

The program will be in the nature of a CPC Conference, with audience participation, on cases presented for review and comment. In each instance the designated faculty member will present a short talk on the subject listed and present a composite case based upon a group of actual maternal deaths in Wisconsin, after which there will be a general discussion of the case reviewed.

Moderator: T. A. Leonard, M.D.
Chairman, Study Committee, Wisconsin Maternal Mortality Survey

Special Problems Related to Eclampsia
Ben M. Peckham, M.D., Chairman and Professor of Obstetrics and Gynecology, University of Wisconsin Medical School

Ruptured Uteri in Relation to Maternal Demise
Frederick J. Hofmeister, M.D., Associate Clinical Professor of Obstetrics and Gynecology, Marquette University School of Medicine

Bleeding Problems in Pregnancy
Thomas A. Leonard, M.D., Clinical Instructor in Obstetrics and Gynecology, University of Wisconsin Medical School

Medical Complications of Pregnancy
George S. Kilkenny, M.D., Associate Clinical Professor of Obstetrics and Gynecology, Marquette University School of Medicine

Anesthetic Problems Related to Obstetrics and Maternal Demise
William Kreul, M.D., Racine, Past President, Wisconsin Society of Anesthesiologists

No registration fee. Academy Credit. Application has been made for category I credit for A.A.G.P. members.

Program Presented by: State Medical Society of Wisconsin
Wisconsin State Board of Health

Suggested Therapeutic Regimens for the Common Bacterial Infections

By BURTON A. WAISBREN, M. S., M. D.*

THE purpose of this paper is to present in a usable, practical manner therapeutic regimens for the common bacterial infections. These are based on extensive laboratory studies and the clinical experience that resulted from the infectious disease control program of Milwaukee County General Hospital.[1–5] We have found the plethora of conflicting claims regarding antimicrobial agents to be confusing to our house staff and therefore have made available to them the information to be presented below. In this manner seriously ill patients can be given the treatment to which they most likely will respond without the necessity of waiting for the results of specific studies. At the present time at Milwaukee County General Hospital the majority of patients are found to be on the optimal antimicrobial therapy by the time results of laboratory studies are obtained. It is for this reason we felt it worth while to share our experience with the physicians of the state.

All *in vitro* studies in our laboratory are done with the tube dilution method,[6] and the information to be presented is based on the determinations of the sensitivity to antibiotics of approximately one thousand strains of bacteria that were isolated from patients on the wards of Milwaukee County General Hospital. This entailed the planting and reading of approximately 100 thousand individual cultures. In the majority of cases the results of the sensitivity tests were compared with clinical results and excellent correlations were observed.

There are doubtless many alternative therapeutic regimens of equal efficacy to those to be presented and no claim is made that these are always the best. Their main virtue may lie in the fact that they have been tested thoroughly on the wards of a large general hospital and in private practice and have been found satisfactory.

*Assistant Clinical Professor of Medicine, Marquette University School of Medicine. From the infectious disease control unit of the Department of Medicine of Milwaukee County General Hospital and Marquette University School of Medicine.

THERAPEUTIC REGIMENS

INFECTIONS DUE TO GROUP A BETA HEMOLYTIC STREPTOCOCCI (STREP THROAT):

1. Treatment of choice: Aqueous penicillin—400,000 units a day for ten days. The first one or two doses should be given intramuscularly and then treatment continued by the oral route for the full ten days.
2. Second choice: Erythromycin—300 mg. four times a day for eight days orally.
3. Patients who have rheumatic heart disease should be given as a prophylactic measure against streptococcic infections 300,000 units of oral penicillin daily. Sulfadiazine or sulfisoxazole (Gantrisin), 0.5 gm., may be given daily instead, but it must be remembered that some strains of group A beta hemolytic streptococci are resistant to the "sulfa drugs." Erythromycin given daily is also effective in preventing recurrence of rheumatic fever.

PNEUMOCOCCAL PNEUMONIA:

1. Treatment of choice: Aqueous penicillin—400,000 units intramuscularly twice a day for four days.
2. If no response, either diagnosis is wrong, or empyema, meningitis, arthritis, endocarditis, lung abscess, pancarditis, or atelectasis is complicating the picture.

FRIEDLÄNDER'S PNEUMONIA

1. If the Gram stain of the sputum of a patient with pneumonia shows gram-negative bacilli, a presumptive diagnosis of Friedländer's pneumonia should be made, 0.5 gm. of chlortetracycline should be given intravenously, and 1 gm. of streptomycin given intramuscularly should be ordered immediately, and then this combination continued at six-hour intervals until clinical response and negative sputum cultures are obtained.

MENINGITIS:

1. If Gram stain shows meningococcus (gram-negative intracellular diplococci), 6 gm. of sulfadiazine should be given imme-

diately intravenously and vigorous therapy with this drug continued for at least one week.

2. If Gram stain shows pneumococcus, the treatment of choice is penicillin, 2 million units intravenously every two hours.

3. If Gram stain is not diagnostic, give immediately 1.0 gm. of chlortetracycline intravenously and 0.5 gm. of streptomycin intramuscularly. This is effective therapy for pneumococcal, meningococcal, *Hemophilus influenzae* and many "staph" meningitides.

SUBACUTE BACTERIAL ENDOCARDITIS:

1. *Streptococcus viridans:* Aqueous pencillin, 400,000 units intramuscularly every four hours, and 5,000,000 units intravenously twice a day for four to six weeks.

2. If sedimentation rate is still up at the end of ten days, change to 10 million units intravenously twice a day, continue intramuscular penicillin, and add 0.5 gm. of streptomycin intramuscularly every eight hours.

3. Enterococcic Endocarditis: In addition to the above, give 0.5 gm. of streptomycin intramuscularly every eight hours for the six-week period. If the spleen remains enlarged and tender, it may have to be removed before cure can be obtained because of splenic abscesses.

INFECTIONS DUE TO GRAM-NEGATIVE BACILLI:

The four most effective antibiotics against each species of gram-negative bacilli are listed in order, and the percentage of strains sensitive to each is in parentheses after the antibiotics. The recommended dose for chloramphenicol and the tetracyclines is 2 gm. a day, for polymyxin B 150 mg. a day, and for nitrofurantoin 150 to 200 mg. a day. Severe infections always should be given initial therapy by the intravenous route.

Escherichia coli		*Aerobacter aerogenes*	
Chloramphenicol	(91%)	Chloramphenicol	(62%)
Nitrofurantoin	(85%)	Oxytetracycline	(44%)
Chlortetracycline	(74%)	Polymyxin B	(37%)
Tetracycline	(71%)	Chlortetracycline	(36%)
Proteus		*Pseudomonas aeruginosa (Pyocyaneus)*	
Chloramphenicol	(78%)	Polymyxin B	(72%)
Penicillin	(38%)	Oxytetracycline	(39%)
Tetracycline	(34%)	Tetracycline	(16%)
Nitrofurantoin	(34%)	Streptomycin	(9%)
Sulfadiazine and sulfisoxazole (Gantrisin) are worth trying in Proteus infections also. Treatment of choice is usually the combination of chloramphenicol, 0.5 gm. orally four times a day, and penicillin, 500,000 units intramuscularly twice a day. In Proteus bacteremia, give the chloramphenicol and penicillin by vein and increase the dose of penicillin to 10 million units twice a day.		*In chronic kidney infection, Pseudomonas aeruginosa will often be untreatable, but if an attempt is made, the suggested program is polymyxin B, 50 mg. intramuscularly every eight hours, and oxytetracycline, 0.5 gm. by mouth every six hours.*	

INFECTION DUE TO AN UNIDENTIFIED GRAM-NEGATIVE BACILLUS:

Statistical order of activity of the antibiotics based on combining data of sensitivity studies done on all species of gram-negative bacilli:

Chloramphenicol	59%*
Polymyxin B	51%
Oxytetracycline	40%
Nitrofurantoin	40%
Tetracycline	36%
Chlortetracyline	32%
Streptomycin	22%
Penicillin	17%

*These figures emphasize the importance of identifying the etiologic bacteria whenever possible.

INFECTIONS DUE TO *STAPHYLOCOCCUS AUREUS*:

The relative activity of the antibiotics is as follows:

Neomycin	96.6%
Nitrofurantoin	95%
Vancomycin	89%
Chloramphenicol	88%
Novobiocin	82%
Erythromycin	77%
Chlortetracycline	48%
Tetracycline	48%
Oxytetracycline	43%
Streptomycin	34%
Oleandomycin	31%
Bacitracin	27%
Penicillin	25%

For practical purposes, these figures make nitrofurantoin the drug of choice for staphylococcic urinary tract infections (it is only effective in the urinary tract) and chloramphenicol the drug of choice in systemic infections. Neomycin and novobiocin should be used in situations that justify the risk of their relatively high rate of toxicity, and all problem infections should be treated on the basis of the sensitivity to antibiotics of the strain of bacteria isolated from the infection itself.

ACUTE PERITONITIS (RUPTURED VISCUS) OVERWHELMING INFECTION:

1. Intravenous chloramphenicol, 1.0 gm. twice a day, and intravenous erythromycin, 1.0 gm. twice a day.

2. If no response to (1) add penicillin, 10 million units intravenously twice a day (Proteus).

3. If no response to (2) change to oxytetracyline, 0.5 gm. intravenously twice a day, and polymyxin B, intramuscularly, 50 mg. four times a day (*Pseudomonas aeruginosa*).

4. If no response add intravenous novobiocin, nitrofurantoin, and/or vancomycin (Staphylococcus).

5. If no response to (4) change to neomycin, 0.5 gm. intravenously twice a day (if neomycin intravenously is used, the patient or his family must be informed that there is a fair chance that deafness will result).

ACUTE PYELONEPHRITIS:

1. If there has been no previous medication, chlortetracycline or chloramphenicol are equally efficacious. Nitrofurantoin and Mandelamine are useful in certain instances. If possible, the first two doses of the antibiotic should be given intravenously.

CHRONIC PYELONEPHRITIS:

1. If the patient is afebrile, it is of doubtful value to treat infections due to *E. coli*, *Pseudomonas species* or *aeruginosa*, or *A. aerogenes*. Proteus should be eradicated with penicillin and chloramphenicol or nitrofurantoin in order to prevent stone formation. Mandelamine will control pyuria and symptoms in many patients with *Pseudomonas species* infections.

PREOPERATIVE PREPARATION FOR BOWEL SURGERY:

1. Neomycin, 0.5 gm. orally every four hours for 24 hours before the procedure.

ACUTE STAPHYLOCOCCAL ENTERITIS THAT FOLLOWS THERAPY WITH OXYTETRACYCLINE, CHLORTETRACYCLINE, PENICILLIN AND STREPTOMYCIN, AND OCCASIONALLY OTHER ANTIBIOTICS:

This constitutes an acute medical emergency, and vigorous therapy with antibiotics and fluids may be necessary for the survival of the patient. The following should be done:

1. The stools are voluminous and watery, and have a distinctive green color. A Gram stain should be done immediately, and if gram-positive cocci are seen, 1 gm. of erythromycin and chloramphenicol should be given intravenously immediately. If the Gram stain shows gram-negative rods, start therapy with parenteral chloramphenicol.

2. All other antibiotics must be stopped.

3. In a severe case, between seven and ten liters of physiologic saline (0.9%) may have to be given to replace sodium and fluid. Eighty milliequivalents of potassium should be given every 12 hours if the urine output is satisfactory.

4. If there is no response in 12 hours, vancomycin and/or novobiocin or neomycin should be given intravenously.

5. The blood pressure should be maintained with norepinephrine.

6. A blood transfusion should be given to further combat shock.

7. If the patient is able to tolerate medication by mouth, neomycin should be given.

REMEMBER THAT:

1. The only indication for the combination of penicillin and streptomycin is in endocarditis due to enterococci or in other special cases of endocarditis.

2. As can be noted from the above, sulfadiazine or sulfisoxazole is not the drug of choice for a single infection with the possible exception of meningococcal meningitis and an occasional case of mild cystitis.

3. There is no indication for any long-acting penicillin except in the treatment of syphilis, where 10 million units of procaine penicillin may be given over a ten-day period.

NAMES OF ANTIMICROBIAL DRUGS

Generic Name	Trade Name
Chloramphenicol	Chloromycetin
Chlortetracycline	Aureomycin
Neomycin	Mycifradin
Novobiocin	Albamycin, Cathomycin
Oleandomycin	Matromycin
Oxytetracycline	Terramycin
Sulfisoxazole	Gantrisin
Tetracycline	Achromycin, Tetracyn
Tetracycline / Oleandomycin	Sigmamycin
Vancomycin	Vancocin
Nitrofurantoin	Furadantin

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(References continued on page 104)

Schizophrenia—A Problem Also for the Internist

By HARRY VANDER KAMP, M. S., M. D.
Battle Creek, Michigan

MANY factors contribute to the apparent lack of interest the internist has in the problem of schizophrenia. Examination of psychotic patients is often an uncomfortable experience. Their behavior is frequently so bizarre and disturbed that placement in a psychiatric ward or commitment to a mental hospital is necessary. The internist thus loses contact with the patient. The formal training of the internist in psychiatry is limited. Furthermore, behavior pathology has been described in rather vague and mythical terms. Thus, internists tend to delegate the care and treatment of the psychotic patient to the psychiatrist.

INCIDENCE OF PSYCHOSES

All practitioners have had patients with psychotic manifestations. It is not an uncommon postoperative complication, especially after prostatectomy, after surgical fixation of a fractured neck of the femur, or after cardiac surgery. Postpartum psychosis is also not uncommon. The internist sees psychosis in various conditions such as vascular or space-occupying lesions of the brain, in toxic conditions such as hyperthyroidism and drug intoxications, and as metabolic disorders such as pellagra and hepatic coma.

It is almost impossible for the practitioner to predict beforehand which patient will develop psychotic behavior. Internists have found that the degree of abnormality of various liver function tests fails to give much help in detecting impending hepatic coma. The degree of atherosclerosis of the basilar and cerebral arteries as found on autopsy, and of arteriosclerosis seen on funduscopy fails to correlate with the degree of mental aberration. The development of acute psychotic behavior is more of a response to stress than a *sine qua non* of the disease itself. Whether or not the psychotic manifestations develop does not depend as much on the severity of the stress as on constitutional factors, genetically determined.

CAUSES OF PSYCHOSES

Clinical experience during recent years has repeatedly demonstrated the amazing changes in psychotic behavior that can be effected by the tranquilizing drugs. Medical literature now stresses metabolic factors as causative in psychoses. Gerard[1] states, "The present evidence seems to speak strongly for heavy weighting of an inherited biochemical aberration as a dominant factor in the causation of schizophrenia." Pauling[2] states, "Most mental disease is chemical in origin and the chemical abnormalities involved are usually the result of abnormalities in the genetic constitution of the individual." Hussey[3] states, "Some mental disorders can be more logically explained in chemical than in psychiatric terms." Fabing[4] maintains that the data now available indicate a metabolic error as the etiological factor in schizophrenia. Diseases due to errors of metabolism are problems for the internist. Schizophrenia is thus a problem for the internist.

The evolution of schizophrenia clinically may be very slow and often unrecognized as such by the physician. It is characterized by acute attacks with intervals of well-being. Later the asymptomatic intervals become shorter, and finally a chronic deforming state persists. It is of interest that preceding the onset of the acute attack there is almost always some traumatic episode. The above description is that given by Thorn and Emerson[5] for gout, except for the substitution of the word schizophrenia.

PARALLELISMS—GOUT AND SCHIZOPHRENIA

Many other parallelisms can be made. Gouty arthritis is brought on by stress such as acute infections, surgery, or exposure to cold, and does not depend on the concentration of uric acid in the blood. The acute psychotic disturbance in schizophrenia is often a response to unusual stress such as pregnancy or the birth of a child, projected marital infidelity, or a change in the family constellation due to death or divorce.

The symptomatic response of acute gouty arthritis to colchicine is often dramatic. The symptomatic response of acute schizophrenia to shock therapy or to the tranquilizing drugs is also often dramatic. The pharmacological action of colchicine in the gouty patient is not known. It has been definitely established

that it does not act by increasing the urinary excretion of urates. So, too, it is not known why shock therapy and the tranquilizing drugs give symptomatic relief in schizophrenia. These also are not curative. The symptoms may not even be causatively related to the metabolic disorder.

METABOLIC ERROR, ENDOCRINE ABNORMALITY MAY BE FACTORS

Gout is a hereditary disturbance of uric acid metabolism. The work of Kallman, Slater, and others has established schizophrenia as a hereditary disturbance. There is increasing data indicating the metabolic error to be of protein metabolism, particularly of the essential amino acids, tryptophane and phenylalanine. Abnormal metabolites of these amino acids have been found in the urine of patients with schizophrenia.[6] Spies[7] describes a urine test for latent pellagra, a disease in which there is a depletion of tryptophane. We have found this test positive in a large number of patients hospitalized for schizophrenia. In patients with carcinoid, there is a positive urine test for a metabolite of serotonin, which, in turn, is a metabolite of tryptophane. We have found results of this test positive in several cases of schizophrenia. However, at this hospital we have been unable to find any correlation between the abnormal metabolites in the urine, the symptomatology, and the response to treatment.

Many inborn errors occur in the metabolism of phenylalanine, as phenylketonuria, tyrosinosis, alkaptonuria, ochronosis, and goitrous cretinism[8] due to enzymatic failure to form thyroxin. Some of these conditions are accompanied by mental aberrations and others are not. In phenylketonuria[9] no correlation can be made between the amount of phenylpyruvic acid in the urine and the clinical symptoms. In all, the 1–1–1 relationship of gene-enzyme-biological reaction is operative. The enzyme tyrosinase, which has a copper component, is active in the metabolism of phenylalanine. Vallee[10] has shown an elevated serum copper in schizophrenia which returns to normal following electroshock therapy. Azima and Richman[11] noted a rise in the plasma copper level in patients with schizophrenia given chlorpromazine. Leach and Heath[12] have shown that plasma from patients with schizophrenia produced a more rapid oxidation of epinephrine than plasma from normal subjects, and they infer that this is associated with increased quantities of copper-containing enzymes. One must conclude that schizophrenia has much in common with diseases considered as inborn errors of metabolism.[13]

All experienced psychiatrists have observed cases in which the patients have a mild form of schizophrenia. These have been described as borderline cases, as pseudoneurotic schizophrenia, or as ambulatory schizophrenia. Such patients rarely need hospitalization, no matter how severe the stress. In contrast, others with a severe form of schizophrenia require hospitalization after being subjected to only minor stress. This peculiar reaction to stress indicates an endocrine abnormality such as is present in diseases of adaptation.[14]

MILD FORM OF SCHIZOPHRENIA

Many patients who manifest the mild form of schizophrenia are being attended by the general practitioner. He has learned through the art of medicine how to recognize these patients and how best to care for them. Their chief complaint is often bizarre and usually referable to the gastrointestinal or genitourinary tract. There is a certain inappropriateness in the emotional tone, a detachment, a coldness and aloofness, which the patient expresses in describing the symptoms. It differs from that expressed by the psychoneurotic. The practitioner is often well aware of the poor social and poor industrial adjustment the schizophrenic makes. This patient is the lonely, shy, seclusive, eccentric individual who is unable to "fit in" with the group. While at work he erroneously concludes that the other workers are talking about him and that they don't like him. He quits his job and seeks another, only to have the process repeated. There may be a long period of unemployment which to the nondiscriminating observer may be considered as laziness. The practitioner has learned that by showing true friendliness and a genuine interest, much can be done for these patients and that the areas in which reality testing is adequate must be strengthened and the areas in which it is impaired must be avoided or handled with a firmness which is not threatening to the patient. The practitioner has thus, perhaps unwittingly, been treating his patient with the form of psychotherapy which psychiatrists at present consider to be best. Now that tranquilizing drugs are available, practitioners can treat patients with a

more severe degree of psychopathology. These should include those on trial visit from mental hospitals.

FUTURE RESEARCH IN SCHIZOPHRENIA

If schizophrenia is due to a metabolic error and an endocrine abnormality with a poorly functioning homeostatic mechanism when subjected to stress, then all social stigmata attached to this illness must be erased. If the metabolic error is determined genetically, a fatalistic attitude must not be taken. There is an adaptive aspect to the formation of even so-called constitutive enzymes.[15,16] The enzyme pattern can be changed, as is illustrated daily in the use of antibiotics and antimetabolites. The biological reaction, too, can be changed. Much is being done with vitamin and hormone therapy such as B_{12}, corticoids, androgens, estrogens, thyroxin, and insulin in other illnesses. Research in schizophrenia must be directed towards determining the enzymatic defect and to replacement and substitutional therapy. Much has been accomplished in diabetes, where the genetic factor is operative. One can hopefully expect that it can be done in schizophrenia, too.

SUMMARY

Schizophrenia has much in common with diseases classified as inborn errors of metabolism and diseases of adaptation—thus a problem for the internist. General practitioners are now caring for many cases of schizophrenia. The number can be increased by proper orientation.

This orientation would erase all social stigmata attached to this disease, instill renewed interest, and facilitate needed basic research.

Veterans Administration Hospital.

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AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY EXAMINATIONS

The next scheduled examinations (Part II), oral and clinical, for all candidates will be conducted at the Edgewater Beach Hotel, Chicago, Illinois, by the entire Board from May 7 through 17, 1958. Formal notice of the exact time of each candidate's examination will be sent him in advance of the examination dates.

Candidates who participated in the Part I examinations will be notified of their eligibility for the Part II examinations as soon as possible.

Hypno-Anesthesia

By V. J. TAUGHER, M. D.
Berlin

IN THE early part of the nineteenth century, Dr. James Esdaile, while working in Calcutta, India, performed several hundred major operations and thousands of minor ones painlessly with the aid of hypnotism.

With the discovery of ether anesthesia, hypnotism in surgery fell into disrepute. Following World War I, interest in hypnotism in surgery was revived and at the present time it is being used in medicine, surgery, obstetrics, and gynecology.

CASE 1

January 3, 1957

A woman, aged 25, who had been delivered under hypnotism, requested hypno-anesthesia for removal of tonsils.

The morning of surgery, her preoperative blood pressure was 126/80, pulse 80. She was given atropine sulphate 0.4 mg. Hypnosis was induced at 7:20 in her room. She was brought to the operating room at 7:30 in a medium trance. The tonsils were dissected and removed and the patient complained of no pain. She did say that all she could feel was pressure and pulling. Blood pressure after surgery was 80/60, pulse 76. Before the trance was terminated, suggestions were given that the patient would have no pain and that she would not bleed. Her postoperative course was uneventful, and she left the hospital on her second postoperative day.

CASE 2

February 28, 1957

A woman, 26 years of age, had been delivered under hypnotism. She entered the hospital on February 27, 1957, for a curettage because of hyperplastic endometritis. She requested hypno-anesthesia. She was given atropine sulphate 0.4 mg. The morning of surgery, hypnosis was induced in her room at 7:30 and she was instructed to help herself onto the cart to be transported to surgery. In surgery, she was instructed to help move herself to the operating table. Her preoperative blood pressure was 130/80, pulse 82. The hypnotic trance was deepened by suggestions to breathe deeply and slowly.

Dilatation was begun at 7:40 a.m. and curettage at 7:47 a.m. Curettage was completed at 8:03, at which time the blood pressure was 110/60, pulse 60.

The patient was then given suggestions that she would have no pain, no insomnia, no nausea. She was discharged after an uneventful recovery on the fourth postoperative day.

CASE 3

April 25, 1957

A married woman, 28 years of age, para I, gravida III, was admitted to the hospital on April 24, 1957, for an elective cesarean section.

At 22 weeks of pregnancy, she had requested that the section be done under hypnosis. She was conditioned by me. Hypnosis was induced every three weeks, and she was able to achieve a satisfactory depth. When she was 36 weeks pregnant, a rehearsal of the entire surgical procedure was done and all the details of the operation were described to her while she was in a deep hypnotic state.

Surgery was scheduled for April 25. On April 22 while in a deep trance, she was told that I would not be able to do her section because I was to undergo major surgery the same day but that she would enter into complete rapport with Dr. A. T. Leininger of Green Lake, who would perform the section.

On the morning of April 25, she was given atropine sulphate gr. 1/150 at 6:30 a.m. She was brought to the operating room at 7:00 a.m. Hypnosis was induced at 7:25 a.m. Blood pressure at the time was 128/80, pulse 86. Surgery was started at 7:55 a.m. Blood pressure at this time was 140/90. There was no bleeding from the skin incision or subcutaneous tissues so it was not necessary to apply clamps to blood vessels. The baby was delivered at 8:03. The mother was awakened to see her baby, and then reinduced. She was quite excited after seeing her baby and did not enter a very deep trance because she could not concentrate properly because of her excitement of seeing a live baby, so it was

necessary to give her a small amount of N_2O at this time. At 8:07 suturing of the uterus was begun. Blood pressure at this time was 80/20, pulse 120. At 8:26 blood pressure was 100/50; at 8:28, 110/60; 8:35, 120/70, pulse 110. Surgery was completed at 8:38 a.m.

On completion of surgery the patient was given suggestions that she would be comfortable, would not experience pain, and would not be nauseated.

She was returned to her room at 8:45 a.m. and remained comfortable. At noon she ate a light lunch, which she retained, and she remained comfortable the rest of the day. Her recovery was uneventful and she left the hospital on May 2.

When questioned following surgery, she stated that she did not feel any pain at any time.

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212 East Huron Street.

YOU ARE INVITED TO ATTEND THE ANNUAL MEETING OF THE WISCONSIN CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS

HOTEL SCHROEDER, MILWAUKEE, MONDAY, MAY 5, 1958

NO REGISTRATION FEE

Registration at 1:00 p.m., Serpentine Room, Lobby

Viewing Scientific Exhibits

SCIENTIFIC PROGRAM

2:00 p.m. Serpentine Room, Lobby

1. **"Disseminated Indeterminate Pulmonary Lesions"**
   John R. McDonald, M.D., Professor of Pathology, Mayo Foundation Graduate School, University of Minnesota, Rochester, Minnesota

2. **"Significance of Heart Sounds in Clinical Medicine"**
   Aldo A. Luisada, M.D., Associate Professor of Medicine and Director, Division of Cardiology, Chicago Medical School, Chicago, Illinois

3. **"Physiological Effects of Exercise in Pulmonary Emphysema"**
   Edwin R. Levine, M.D., Assistant Professor of Clinical Medicine, Chicago Medical School, Chicago, Illinois

4. **"An Analysis of the Radiation Hazards and Rewards of Chest X-Rays"**
   Jerome L. Marks, M.D., Chairman of Department of Radiology, Milwaukee County General Hospital; Assistant Clinical Professor of Radiology, Marquette University School of Medicine, Milwaukee

5. **"Physiological Defects in Pulmonary Diseases"**
   George R. Meneely, M.D., Associate Professor of Medicine, Vanderbilt University School of Medicine; Associate Professor of Clinical Medicine, Meharry Medical College, Nashville, Tennessee

6. **Panel Discussion Covering Subjects Presented by the Speakers, With Questions from the Floor.**

Any inquiries on details of the program may be addressed to Dr. L. H. Hirsh, secretary–treasurer, 238 West Wisconsin Avenue, Milwaukee 3, Wisconsin.

Histoplasmosis in Wisconsin

As It Looks to Your State Board of Health

THE picture of histoplasmosis that has gradually evolved over the past decade or so is extremely interesting. The concept of a rare disease almost invariably fatal or associated only with local oropharyngeal lesions has changed remarkably. It is now recognized that the clinical spectrum includes illnesses varying from a mild grippe-like illness or an acute pneumonitis to a chronic, progressive pulmonary disease.

Much valuable information has been obtained from the skin test surveys which have been done over the nation. Through these surveys a definite geographic distribution on the basis of a skin test reaction has been determined. Unfortunately, it has been assumed by many physicians that if they practice outside widely recognized highly endemic regions the possibility of histoplasmosis in their patients is negligible.

Within these large areas in which the level of skin test sensitivity is known the distribution of *Histoplasma capsulatum* in the soil and environment is undoubtedly quite irregular. For example, an outbreak of histoplasmosis involving 19 cases occurred recently in a small community in Wisconsin. All the patients had exposure to an excavation in a harmless looking lot. A subsequent skin test survey with histoplasmin showed that 15.7 percent of the townspeople were positive while only 4.3 percent of the people from surrounding areas were positive. Since person-to-person spread of histoplasmosis has not been demonstrated, it may be assumed that a source of the organism was present in the community and that such sources existed to a much smaller degree or not at all in the surrounding rural area. One cannot be certain that in a given community or small area a source of *H. capsulatum* does not exist.

The clinical picture of histoplasmosis has been well described in the literature.[1,2] An acute pneumonitis is usually associated with histoplasmosis. However, the disseminated form, which may be indistinguishable clinically from "aleukemic" leukemia, and the chronic cavitary form, which may be indistinguishable from tuberculosis clinically, should be emphasized. The death from disseminated histoplasmosis last year of a three-month-old infant from north central Wisconsin who had an illness resembling leukemia emphasizes the necessity of being alert to the possibility of this disease in such cases.

The importance of diagnosing histoplasmosis as early as possible has increased recently because of developments in treatment. Intravenous therapy with amphotericin B has given promising results in preliminary clinical trials on disseminated cases found early in the course of the disease and on chronic progressive cases.

The tentative diagnosis of histoplasmosis can occasionally be made on the basis of physical examination, chest x-ray, and history alone. A compatible clinical picture combined with exposure to a possible source within the previous three weeks may lead one to the diagnosis. Common sources include soil disturbed by activity (digging, plowing, etc.), dust contaminated with bird or fowl droppings, and dust derived from old, rotting wood. Inhalation of contaminated dust is the usual route of exposure. Diagnostic workup should include histoplasmin skin test, complement fixation test on acute and convalescent blood, and culture of sputum, bone marrow or lymph nodes. These diagnostic materials and services are available through the State Laboratory of Hygiene.

There are undoubtedly many localized areas within Wisconsin where the incidence of histoplasmosis is much higher than would be expected on the basis of nationwide studies. At present there is no way to predict where these areas are. A high index of suspicion of histoplasmosis as a possible diagnosis in all cases with compatible clinical picture will detect many cases, and if these are reported to the State Board of Health the areas that are most heavily infected will become apparent.—KENNETH R. WILCOX, JR., M.D., *Officer in Epidemiology Intelligence Service, Communicable Disease Center, U.S. Public Health Service, assigned to Wisconsin State Board of Health.*

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Clinicopathologic Conference

Sponsored by the Section on Pathology, State Medical Society of Wisconsin
Guest Editors: C. H. Altshuler, M. D., and J. Bareta, M. D.

PROTOCOL*

A 37-year-old gravida 4, para 3 entered the hospital in labor. Onset of the first stage of labor had begun approximately 1 hour and 20 minutes prior to entrance to the hospital. On admission, the membranes were intact.

Family History: Noncontributory.

Previous Illness: Noncontributory.

Menstrual History: Onset, 13 years of age. Her periods were every 28 days and lasted 5 days. She had moderate bleeding and no pain. Her previous pregnancies were said to have been uneventful. Her children were living and well.

Physical Examination on Admission: The lungs were clear to auscultation and percussion. The heart was not enlarged and no murmurs were heard. The rhythm was regular. The patient's uterus extended to the xyphoid process and was symmetrical. The remainder of the physical examination was noncontributory.

Laboratory Examination on Admission: Urinalysis: reaction alkaline, specific gravity 1.015, negative for sugar. Occasional epithelial cells were seen on microscopic examination. The hematocrit was 50%. Serology negative. Prothrombin time 84%.

Hospital Course: Approximately three hours after admission, the patient spontaneously delivered a live female infant in good condition. It was estimated that she lost 375 cc. of blood. Difficulty in breathing and cyanosis appeared immediately after delivery. At that time cough and a shocklike state were also noted. These symptoms were accompanied by a pink, frothy sputum. The history revealed that the woman had had several bouts of palpitations associated with dyspnea without cough or chest pain in the past two years. She had had no history of hypertension. On physical examination, the consultant found that she was dyspneic and had some cyanosis of the nail beds. The heart rate was rapid, 170 per minute. Moist rales were heard throughout the lungs. No abnormality was noted in the abdomen. No edema was observed in the lower extremities, although varicosities were seen. A vulvar varicosity had been ligated at the time of delivery. The blood pressure was 70/40.

A portable chest film was interpreted as revealing patchy areas of increased density in both lung fields. The areas were believed to be due to pulmonary edema.

The patient was given aqueous penicillin, Isuprel, Alevaire, 70% alcohol-aerosol, and 50% glucose with aminophylline. Approximately four hours after the development of shock, the woman's pulse became stronger. Her respirations were rapid but her color improved. Fourteen hours after admission her blood pressure, which had been 86/70, was 84/60. Dyspnea persisted and her pulse rate remained rapid (120). Her blood fibrinogen was 260 mg./100 ml. Examination of the sputum revealed no malignant cells. Twenty hours after admission, tachycardia and cyanosis were still evident. The blood pressure was 106/60. A loud, blowing systolic murmur was said to be present at the apex. Coarse rales were heard, particularly in the right lung. The liver was palpable two fingerbreadths below the rib cage. The patient was digitalized and placed on Dicumarol. On the second hospital day, she was markedly improved and her pulse rate fell to 84. Her blood pressure was 96/66. Only a few moist rales were heard at the right base, and the liver was no longer palpable. On the evening of the second hospital day, the patient complained of pain in the hips and legs. She had numbness of the hips and was unable to raise them off the bed. Homans' sign was equivocal. Mild tenderness was noted in the legs. Her clinical condition continued to improve, however, and on the sixth day no calf tenderness was present and the patient was gradually allowed to become ambulatory. She was

* From St. Joseph's Hospital, Milwaukee.

told to wear elastic stockings. A chest x-ray at that time was reported as follows: "The lung fields are now entirely clear. They are normal. The heart is within the limits of normal in size. Nothing unusual is noted in the contour. If there are any clinical findings such as murmurs, recommend fluoroscopy." An electrocardiogram taken on the seventh hospital day was interpreted as normal. On the tenth hospital day, the nonprotein nitrogen was reported as 31 mg./100 ml., chlorides 108 mEq./l., sodium 138 mEq./l., and potassium 6.04 mEq./l. The patient was discharged from the hospital on the eleventh hospital day.

Approximately six months after discharge, while bending over to clean a couch she became dyspneic, coughed up bloody frothy sputum, and died.

CLINICAL DISCUSSION

Dr. C. H. Altshuler: Dr. Julius Meyer will discuss the clinical aspects of this 37-year-old woman whose protocol has been presented to you.

Dr. Julius Meyer: This case is fascinating in many ways and affords an opportunity for the accomplishment of some of the things one should try to achieve in a clinicopathologic conference. Whether the diagnosis is obvious or obscure makes no difference. The main purpose of CPC's is for one to learn something—either one learns where a mistake has been made in diagnosis or in treatment, or he may pick up clues as to a method of making a diagnosis. Again, one may encounter a disease entity in which the history, physical examination, and perhaps some of the laboratory findings resemble those of other diagnoses.

There are many ways in approaching CPC's. As far as the diagnostic procedure is concerned, one might select a group of symptoms and run through an extensive differential diagnosis for each pertinent fact and then at the end try to tie the whole thing together. This probably is more an exercise in semantics than a thing of practical value. It seems preferable to summarize the basic facts in the protocol, and these, unfortunately, don't always represent all of the facts in the case—not that the people who prepare the protocol deliberately omit the facts (although they have been known to do so), but many times the observations made by the clinician at the time of the examination are recorded mentally. As time goes on, some of these facts attain great clinical significance.

This woman entered the hospital for the delivery of her fourth child. Apparently she was perfectly well. She had delivered three children before, without any difficulty. Labor and delivery proceeded perfectly normally and there was no particular difficulty with the birth of the child. In the two years before the delivery of this child she previously had had several episodes of palpitations associated with dyspnea, but without cough or chest pain. Other than this, the history was entirely negative. The physical examination on admission was perfectly normal except for the term pregnancy. The initial urinalysis was normal; only the hematocrit was done and it was somewhat elevated; the prothrombin time was perfectly normal. So up to that point we have no indication of any difficulty whatsoever. However, immediately after delivery, which resulted in a moderate blood loss, a dramatic group of symptoms developed rather rapidly. The patient began to have difficulty in breathing and cyanosis. A cough and a shocklike state developed and an undetermined amount of a pink frothy sputum was brought up. The exact amount brought up would be of some diagnostic importance but it isn't recorded, unfortunately. On physical examination, she was seen to be dyspneic, she had slight cyanosis of the nail beds and a very rapid pulse rate (170). The cardiac rhythm was regular. The lungs were filled with rales. There was no peripheral edema, although there were varicosities of the extremities and vulva. The blood pressure at this time was 70/40. Apparently—I'm not quite clear as to the time element here—her liver became palpable within a period of not more than 14 to 20 hours. As you see from the protocol, her blood pressure gradually rose. For a period of 20 hours her dyspnea, tachycardia, and rales persisted. One additional fact, which may be of importance from a diagnostic standpoint, was the appearance of a loud, blowing systolic murmur at the apex. This is an interesting finding in view of the fact that apparently the patient had never had this murmur before.

She was digitalized, was given vasodilators and Dicumarol, and improved markedly in approximately 24 hours, as I gather from the protocol here, which states that on the second hospital day she was markedly improved. The rales cleared rapidly, and the liver was

no longer palpable. This is a very rapid change in liver size. On the second hospital day, she noted pain in the hips and legs and numbness of the hips—she couldn't raise them off the bed. An equivocal Homans' sign was found and mild tenderness was noted in the legs. The x-ray examination of the chest is recorded as the "heart's transverse diameter is now larger than it was before, although the heart is within normal limits. Nothing unusual is noted in the contour. The lung fields are clear." Another interesting statement that the X-ray Department made is that "if there are any clinical findings, such as a murmur, fluoroscopy is recommended." If the heart size is normal, the contour is normal, and the lung fields are clear, why does the X-ray Department say if there is a murmur present, recommend fluoroscopy? This question should be answered by the X-ray Department. An electrocardiogram on the seventh day was interpreted as normal. Laboratory studies revealed a nonprotein nitrogen of 31 mg. 100 ml., chlorides and sodium within normal limits, and potassium a little elevated. Again the next day, the serum potassium level was 5.27 mEq./l. The patient did well and was discharged from the hospital on the eleventh hospital day. One of the most important things that we do not know from this protocol is whether or not the murmur which was heard at the apex persisted throughout the remainder of the hospital stay. Its subsidence would be of great importance in one way and its persistence would be of significance in another way.

Approximately six months after discharge, while bending over to clean a couch the woman became dyspneic, coughed up bloody, frothy sputum, and died. This, I presume occurred within a matter of a few minutes.

Before proceeding I would like to hear a discussion of the x-ray findings in more detail.

Dr. J. F. Wepfer, radiologist: The initial film, dated January 16, 1957, is a portable one. You will note the bilateral, patchy, and rather soft-appearing infiltration which is rather characteristic of pulmonary edema. The heart is normal in size. Twenty-four hours later, there is marked improvement, the major portion of the persisting edema being seen only in the right mid-lung field. On January 22, 1957, her heart is still normal and the lung fields are entirely clear.

With regard to the question Doctor Meyer asked, we were aware of the episode of pulmonary edema, of course, and I think that the report was worded so that an effort would be made to rule out early mitral disease. Actually the size is not too impressive.

Doctor Meyer: Percentage-wise, the most likely cause of a calamity of this sort at the time of delivery is pulmonary embolization arising from thrombi in the pelvic veins. It is wise to make a distinction between pulmonary embolization with and without pulmonary infarction, because the embolic phenomenon is somewhat similar to coronary insufficiency. Initially with pulmonary embolization, there is a decrease in circulation and it may clear completely without much, if any, infarction. One may have temporary anoxia because of the decrease in circulation and yet not have pulmonary infarction. Usually, however, most pulmonary emboli will go on to infarction.

The arguments for this diagnosis are impressive. First of all, the patient was a woman who had varicose veins; she had a vulvar varicosity; she had delivered a child; and acute respiratory distress had developed, which is so common with pulmonary embolization. She had the cyanosis, tachycardia, and a shocklike state with a falling blood pressure, all of which can occur with embolization. In addition, the subsequent picture of rapid recovery with a bronchodilator would certainly lead one to suspect an episode of this type. Further evidence seems to arise from the findings of calf tenderness and the numbness and aching in the hips. Also, the picture of apparently complete recovery in 11 days and a subsequent acute and fatal episode tends to substantiate the diagnosis. Pulmonary infarction, of course, is one of the common causes of sudden death.

There are some intriguing aspects of this case, however, that make me wonder whether we shouldn't look for some other explanation of the patient's difficulties. First of all, the description of what happened at the time of delivery is suggestive of left heart failure. Acute pulmonary edema can produce almost the same clinical picture, and the patchy areas in the lung fields which were noted on x-ray were believed to be due to edema. Somewhat against this idea is the fact that,

although the woman had tachycardia, she did not have a steady or elevated blood pressure, which is the ordinary sequence of events in acute left heart failure based on prior left heart damage. One thing which would result in left heart failure on an acute basis is acute myocardial infarction. That, of course, would require an explanation as to why the patient should have an acute myocardial infarction. The timing of the event is not against the diagnosis. Acute myocardial infarction occurring after delivery has been noted before. One could postulate, too, either an anomalous coronary vessel or some other type of anomaly which might produce acute left failure. Another possibility is a Lutembacher syndrome. In its milder form it may escape detection and is compatible with life without cyanosis. Ordinarily, of course, the left ventricular pressure rises markedly, particularly with mitral stenosis, and the flow is from left to right and the individuals remain acyanotic. You could even tie the Lutembacher syndrome and pulmonary embolization together and speculate that if an individual had acute pulmonary embolization, which ordinarily would throw him into right failure, the right ventricular pressure might rise and reverse the usual flow and produce cyanosis. In any event, acute left failure, which I believe was present in this patient, will respond many times as dramatically as this. In Doctor Levine's book, he has cited many instances in which patients with acute left failure recovered almost unbelievably in six to twelve or twenty-four hours after appropriate therapy was instituted.

There are a couple of other things which must be mentioned as diagnostic possibilities. One possibility with which I, personally, am not too familiar is so-called amniotic shock or placental shock, amniotic embolism. Apparently this was the thought of the clinician in obtaining a blood fibrinogen determination. It was normal. Many people with amniotic fluid embolization apparently have a marked decrease in their blood fibrinogen level. Another entity which I have seen described in the obstetrical and gynecological literature is the so-called "postpartum Addisonian crisis," in which, for some unknown reason, one will get a picture of mild adrenal insufficiency. It does not ordinarily present, however, the acute shocklike picture which characterized our present patient. One thing which might fit this diagnosis was the finding of a slightly elevated blood potassium. No other evidence is at hand to support the "Addisonian" diagnosis.

The electrocardiogram was reported as being within normal limits and I think that this is the type of report that should be made on the electrocardiogram, although it is interesting that this electrocardiogram shows some rather sharp T waves which are rather above normal in altitude. This may be found with hyperkalemia, but it may be found in normal individuals, too. Occasionally, it has been seen as the only manifestation of myocardial infarction.

On the basis of the information at hand, we would have to say that this patient most likely suffered with pulmonary emboli, and acute heart failure developed on this basis—both right and left heart failure. She recovered from her initial episode, and ultimately a massive and fatal pulmonary embolus developed, six months after her discharge.

Doctor Altshuler: Thank you, Doctor Meyer. Are there any questions for Doctor Meyer before we have the autopsy findings?

Dr. K. E. Sauter: How often do murmurs develop in pregnant women?

Doctor Meyer: Is this a general question or are you asking about this case? Various types of murmurs frequently develop during pregnancy, and if you listen to the heart from month to month you will hear the murmur developing, hear it change, and hear it disappear after the birth of the infant. The reason I think this one is different, and important, is that it was a murmur which was never heard afterwards. I don't think that that type of murmur—heard once and never heard again—is a common thing.

Doctor Altshuler: Doctor Meloy was the attending physician. I wonder if he can give us more information about this murmur. Was it heard in the antenatal period and/or was it heard subsequently?

Dr. G. E. Meloy: I had the privilege of taking care of this patient before and after delivery. She had no murmurs before the episode at the time of delivery. The murmur was noticed only in the delivery room. On subsequent visits she had no murmur. I saw her in the office several times.

I might add a few things about the history. From the time she left the hospital

until the time she died, I saw her, as I said, on several occasions, and at each examination her heart appeared to be normal, her blood pressure was normal, and her lungs were clear. Her varicosities presented no particular difficulty. I had her wearing elastic stockings most of the time, and no thrombosis developed anywhere that could be seen. With regard to the dizzy attacks and palpitations that she had prior to delivery, they also occurred after delivery. They weren't as common, and I was at a loss to explain them. She told me that if she rested and took some of *my medicine* she felt better (laughter). I might add that at no time did she ever have auricular fibrillation. She had electrolyte studies done following discharge from the hospital. Her potassium continued to be about 5.3 mEq./l.—I think that was about three months after delivery. We couldn't explain this slight elevation of potassium.

At the time of her death she was cleaning a davenport, bending over, and suddenly became ill. The illness was characterized by weakness, cough, and shortness of breath. She went to the bathroom and coughed up a considerable amount of "blood." Her sister called me and I told her I would come as soon as possible. I think I was there in probably about 25 to 30 minutes and she was dead when I got there.

Dr. Samuel Rosenthal: I would like to ask Doctor Meyer if he attaches any significance to the fact that shock developed while the patient was bending over the couch.

Doctor Meyer: Not particularly. There are some things that ran through my mind, such as straining which might cause an increased intracardiac pressure—this resulting in the reversing of a pre-existing shunt and suddenly raising the pulmonary blood pressure to produce acute pulmonary hypertension. That could produce dyspnea and pain but I haven't seen it actually go on to cause sudden death in this type of situation. The episode of standing over the couch also might produce a milking effect as far as pelvic veins or leg veins are concerned. That would be of significance in pulmonary infarction.

Doctor Altshuler: Doctor LaBissoniere, you saw the patient in consultation. Would you care to comment on your findings—what your impressions were?

Dr. Paul G. LaBissoniere: When one sees an individual in an acute state of cardiovascular or cardiopulmonary distress following pregnancy, several considerations come to mind, and these Doctor Meyer has covered most thoroughly. We must decide whether this episode is incidental to or consequential of the pregnancy, that is, whether or not it was due to antecedent disease not truly associated with the pregnancy or due to a complication of the pregnancy itself. We found nothing in the history, physical examination, or in previous chest films to suggest that the patient had previous cardiac or pulmonary disease, and we felt therefore it was proper to conclude that what had happened to her after delivery was a complication of the pregnancy itself. We felt that the events that followed tended to suggest that we were correct in this instance. It was our impression that the picture was that of acute cor pulmonale with both right and left heart failure. We, too, felt that the immediate cause was embolization; and I think that Doctor Meyer's distinction of pulmonary embolus with infarction in contrast to that without infarction is an excellent one.

We had occasion to see another pregnant woman in this hospital who had a presystolic murmur at the apex. We felt that she had had mitral valvular disease—mitral stenosis. She had a murmur from the time she was first examined by members of the staff. In this instance the patient made no response to treatment and died. At autopsy, she was found to have multiple pulmonary emboli and no valvular disease at all. Nevertheless, her picture was that of mitral valvular disease even on cardiac fluoroscopy, which was done subsequent to her pregnancy. It showed the typical picture of a large left atrium without left ventricular enlargement.

Doctor Altshuler: Due to the lateness of the hour, I think we'll give you the autopsy findings and offer what we think is probably the sequence of events. At autopsy, the patient had acute pulmonary congestion and acute pulmonary edema. The heart was not remarkably enlarged. The significant finding was a pheochromocytoma of the left adrenal gland. The tumor was analyzed by Sister Verona and it was found that, of the catecholamines present, the largest proportion was adrenaline, although a small quantity of noradrenaline was also found.

In order to understand the clinical situation, I think one has to keep certain physiological factors in mind. First, it has been demonstrated that many individuals who have a pheochromocytoma become adrenaline-fast—that is, if one were to inject one cubic centimeter or even two cubic centimeters of 1:1,000 solution of adrenaline, no significant response would be observed. Secondly, we have to remember that these catecholamines exert their influences through so-called adrenergic receptor sites. There are two varieties, the so-called alpha, the stimulatory or excitatory variety, and the beta variety or the inhibitory receptor site. The catecholamines, as you know, have different physiological actions. For example, adrenaline causes tachycardia; it causes an increase in cardiac output; it causes both vasoconstriction and vasodilatation; and it may induce hyperglycemia. Noradrenaline ordinarily does not cause tachycardia and has a vasoconstrictive effect without a vasodilatory component.

It is interesting that in some of the original work done by Barger and Dale[1] it was found that certain alkaloids from ergot would block certain aspects of adrenaline action and would not block other effects. It was found, for example, that the ergot alkaloids would block the excitatory action of the adrenaline (the vasoconstriction, *e.g.*) but would not have any effect on the vasodilatory (inhibitory) activity. Thus, in their experiments, adrenaline actually caused a hypotension when given with ergotamine. This phenomenon was called "adrenaline reversal." It's interesting, then, and perhaps significant, that this patient received ergotamine intravenously, as do most of our postpartum patients. It appears possible, therefore, that the ergotamine in this instance had something to do with the development of her shocklike state. In other words, the large amounts of adrenaline circulating had their vasoconstrictive action blocked, but the vasodilatory component persisted unopposed. If that occurred, a shocklike state would not be unexpected.

In the cases of pheochromocytoma that have been reported, several showed a persistent elevation in blood potassium. In our laboratory, 4 to 4.5 mEq./l. is normal, and this patient's blood potassium in all determinations was persistently elevated. We think that her bending over at the time that she had her fatal attack probably put pressure on the pheochromocytoma and liberated a large amount of catecholamines into the circulatory system suddenly. At least, this type of pressure has been incriminated frequently in the literature.

Doctor Rosenthal: I should like to ask Doctor LaBissoniere if, in retrospect, he felt the diagnosis of pheochromocytoma was possible?

Doctor LaBissoniere: Doctor Rosenthal, I thought your question to Doctor Meyer was quite pertinent because it is well known that massaging the area where the tumor lies is an excellent way to produce an event such as occurred to this lady terminally. For this reason the surgeons are very cautious about ligating the vessels to the involved gland before manipulation. There were only two things, as far as I can see, that might have indicated to us that a diagnosis of pheochromocytoma was a possibility in this case—the syncopal episodes that were not accounted for on any other basis and the terminal event of sudden death on bending over. Doctor Altshuler mentioned that the patient's glands contained chiefly adrenaline. Is that right?

Doctor Altshuler: That's right.

Doctor LaBissoniere: The situation is usually the reverse in most cases of pheochromocytoma. Norepinephrine is usually more prominent than the epinephrine quantitatively. Norepinephrine has a greater effect on the vasculature, has a greater hypertensive effect, and produces the vascular changes associated with hypertension. That's probably the reason that hypertension was not a clinically prominent feature in this case.

Doctor Altshuler: The patient did have a blood pressure of 140/80, a slight elevation of the pulse pressure. That is on the antenatal record. And you know that adrenaline does cause an increase in the systolic pressure more than it does in the diastolic pressure so that an increase in the pulse pressure is expected. This minor finding, therefore, should be added to the other features which would tend to suggest the diagnosis.

Doctor LaBissoniere: Did you say anything about why these individuals die suddenly?

Doctor Altshuler: No, go ahead.

Doctor LaBissoniere: Well, I'm not really sure I know, but there is a great deal of interest in this problem now. It has been demonstrated that the blood catecholamines are high in a certain number of other conditions and that one of the most important of such conditions is probably renal insufficiency because the catecholamines are excreted through the urine. We also know that the heart muscle has a great affinity for the catecholamines and takes up more of these substances than any other tissue of the body. For this reason, in conditions associated with high levels of catecholamines, the heart muscle and especially the conductive system may become susceptible to disastrous and catastrophic arrhythmias. I believe that that may have produced the terminal event in this case.

Doctor Altshuler: In this connection, I might point out that Mayock and Rose,[2] who studied both the blood and tissue potassium in patients with pheochromocytoma, found the blood potassium elevated during the intervals between the attacks but that during the attacks the blood potassium fell rather precipitously. This is opposite to what one might expect, I think, inasmuch as the tissue potassium is quite markedly elevated. It was found that the tissue potassium content in pheochromocytoma was approximately 170 mEq./gm. of wet tissue. The normal is about 70. I think this type of data might be supportive of Doctor LaBissoniere's contention.

Dr. A. F. Kustermann: How large was the tumor?

Doctor Altshuler: The tumor weighed 25 gm. and measured approximately 4 cm. in diameter.

Doctor Meloy: Were there metastases?

Doctor Altshuler: No metastases. There was a little nodule in the liver and, at the time of autopsy, we thought it might represent a metastasis, but it turned out to be a hamartoma of the adenomatous variety.

Doctor Rosenthal: I think the important thing that we must remember is that if one sees an individual with paroxysmal hypertension, the possibility of pheochromocytoma should be considered.

Doctor Altshuler: This woman did not have paroxysmal hypertension.

Doctor Rosenthal: I know she didn't. But I was just saying that if you *do* see a patient with hypertension, either paroxysmal or persistent, that a pheochromocytoma should be considered.

Doctor Altshuler: Before you arrived, Doctor Rosenthal, Doctor Meyer remarked, very cogently, I think, that a CPC is intended to demonstrate cases which have a rather atypical picture—that the condition present in some may be easily confused with other conditions. If there was ever a case that sounded like pulmonary embolism from the clinical story, this one did. I don't think that rationally one could have made the diagnosis of pheochromocytoma unless he had the complete biological picture, that is, the clinical course, the mode of the death, the persistent elevation in blood potassium, the position the patient was in when she died, and so on.

I think everybody is well aware of the usual picture of a pheochromocytoma.

Doctor Rosenthal: I disagree with you, Doctor. Until 1950 there were only about 250 cases reported. There are many more, I'm sure, but we only diagnose what we see. We must keep this diagnostic possibility in mind.

FINAL DIAGNOSIS:

Pheochromocytoma, left adrenal.

Acute pulmonary congestion and edema.

Acute passive congestion, liver, spleen, adrenals, kidney.

Hamartoma (adenoma), liver.

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Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee
F. E. SHIDEMAN, M. D., University of Wisconsin, Madison

Two Interesting Therapeutic Departures

The two following summaries of recently reported observations are brought to the reader's attention only because, if experience proves them confirmable, these new therapeutic "tricks" will conceivably be of great usefulness in their respective fields.

The first concerns the use of probenecid (Benemid) in the treatment of rheumatoid arthritis. Michael Felhendler,[1] in Sweden, inadvertently used this drug in a patient with rheumatoid arthritis and observed such dramatic improvement that he extended the trial to include 226 patients, in 93% of whom considerable improvement occurred. There was, however, an initial transitory deterioration in practically all instances. Shortly after starting probenecid therapy, the affected joints were more painful and previously unaffected joints became painful. All the inflammatory signs, and sensitivity to temperature changes, increased, and there was often severe headache, a feeling of extreme fullness in the head, and great lassitude. Improvement began only after a few weeks of the probenecid therapy. Obviously, longer observations, placebo controls, and detailed analyses, including determinations of uric acid clearance, are needed before the role of probenecid can be definitely evaluated in the treatment of rheumatoid arthritis. Presently, the established use of this drug is in the treatment of gout, in which it increases the loss of urates in the urine.

The second observation is that of Murray Bergman,[2] who reports the control of odor, dermatitis, and ulceration associated with ammoniacal urine through the use of dl-methionine, which he gave in 0.2 gm. (3 grain) capsules 3 times daily to 86 patients who were incontinent of urine. The trial was limited to individuals with extremely strong odor and those with severe ammonia dermatitis and papular eruptions on the buttocks and thighs. These cases were said to have been so severe that it was difficult for staff members and other personnel to stay on the ward for long periods without seeking less offensive air. Within a week of institution of treatment there was pronounced reduction in odor, disappearance of rash, and clearing of ulcerations and pustules. In a few patients, the degree of incontinence decreased. When medication was discontinued, the odor immediately reappeared with rash and swelling. This experience of Bergman will doubtless be of considerable interest to those concerned with the management of patients in mental institutions, nursing homes, and wherever the incapacitated and senile are cared for.
—HARRY BECKMAN, M. D.

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CARDIAC WORK CLASSIFICATION UNIT ESTABLISHED BY MARQUETTE

A Cardiac Work Classification Unit to evaluate people with heart disease from the standpoint of the type of employment they are capable of doing and their work capacity has been established by Marquette University School of Medicine. The unit is housed at Milwaukee County Hospital.

Dr. George Hellmuth, associate professor of medicine at Marquette, and director of the cardiovascular unit at Milwaukee County Hospital, will supervise the program. A team consisting of a cardiologist, vocational psychologist, and social worker will evaluate each patient.

The unit is not a diagnostic or treatment center. It will be operated through referrals by private or industrial physicians. There will be no charge to patients. Recommendations will be made to the patient and his employer about continuing present employment. If the patient has no regular employment or cannot continue his past employment, aptitude testing will be done to determine capabilities for occupations lying within the range of his physical tolerance. Vocational training will be advised and arranged when indicated. Each person will be evaluated from a medical as well as a social and psychological standpoint.

"Wake in our breast the living fires,
The Holy faith that warmed our sires. . . ."
OLIVER WENDELL HOLMES, M. D.

. . . gleanings from the Section on Medical History

A veteran Sheboygan barber, Otto Winingstad, recently described to State Historical Society fieldmen the bloodletting performed by barbers a generation ago.

Bleeding, an ancient practice, was accomplished by a bleeding block operated by a spring which released a series of blades. This was used, Winingstad said, for high blood pressure, "to get rid of the bad or tired blood which didn't circulate." He also said it was used on persons troubled with rheumatism, arthritis, skin diseases, and obesity.

"One woman, some 300 pounds or so, would come in twice a year, and get 25 cuppings each time," Winingstad said.

In the rheumatism treatment, he said, 20 cuts were made at one time, then a bleeding cup was placed over the incision and blood drawn out by a vacuum process induced by passing an alcohol flame over the cup.

"One time we had a factory hand who was so crippled from rheumatism he couldn't work," the barber related. "After two months of bleeding, the fellow returned to work in good health. Doctors Genter, Maught, and St. Sure would send patients to us barbers.

"I don't recall any shock cases from the bleeding. We didn't treat any cardiac cases. The only anesthetic we used was a shot of whisky. The last bleeding and cupping I know about in these parts was done about 15 years ago."

Those were the days before the State Board of Health. Barbers' itch was said to have been a common ailment. Its spread can be blamed on the lack of sanitation by the barbers themselves, some of whom were in ill health. This is one reason why many customers had their own shaving mugs.

With a number of other barbers, Winingstad circulated a petition in 1902, asking for a workable sanitary code for barbers. Lawyers, doctors, businessmen, and others signed it, and a code followed.

Winingstad said barbers in Sheboygan also engaged in needling. The gadget used was a sort of rotary vibrator with spikes at its base. On snapping the spring, the multiple needles would prick a wide surface on the back of the hand. Ointment was rubbed over the pricked area, producing a blister of considerable size. This, he said, was used for nervous disorders and rheumatism "with great success, and the blister healed overnight."

(Bleeding and needling devices are being sought for the Medical Museum of Wisconsin, which will become a reality at Prairie du Chien in several years. If you have one or more of these gadgets, or know where they might be obtained, will you please write to the Section on Medical History, Box 1109, Madison 1).

* * *

More and more interest is being generated by local historians in uncovering information about the first physicians in various localities in Wisconsin. To cite some examples:

The first doctor in St. Croix Falls is believed to have been Doctor Aldrich, who also served the area as mail carrier. That was in the early 1840's. Doctor DeWitt came in 1846, and Dr. Otis Hoyt three years later. Dr. Samuel Deneen arrived in the area in 1855. He also served as lawyer, teacher, preacher, coffin maker, miller, farmer, and postmaster. The first M.D. in Osceola was Doctor Gray, who practiced in that community more than a century ago.

The above information was found in "Early History of the Friendly Valley and Falls of St. Croix," written by Maggie Orr O'Neill of St. Croix Falls. It was sent to the Section on Medical History by Mrs. J. A. Riegel of St. Croix Falls.

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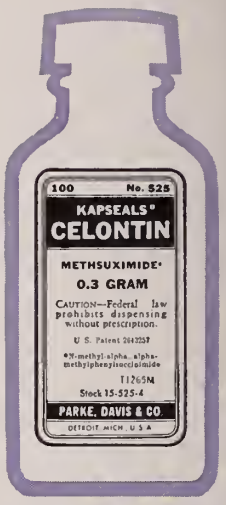

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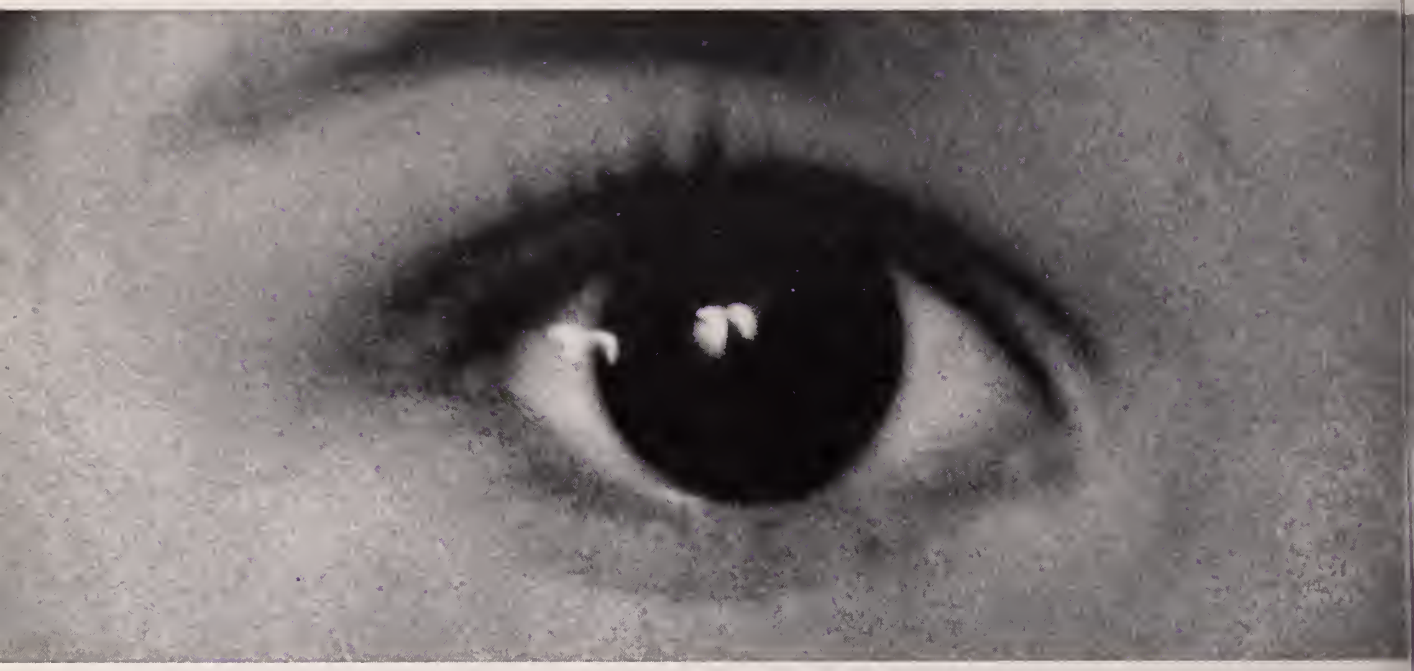

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Volume 57
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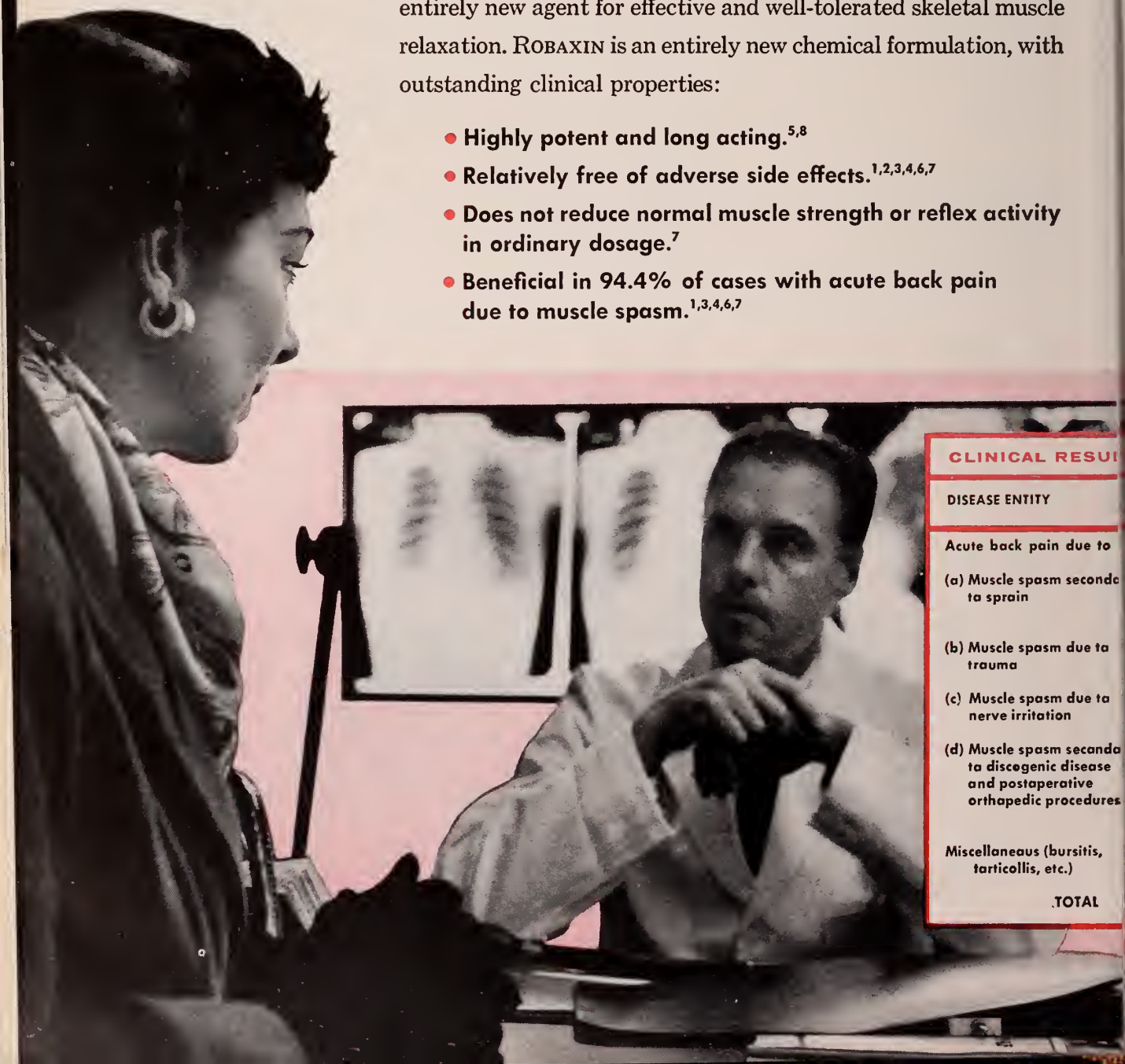
- **Beneficial in 94.4% of cases with acute back pain due to muscle spasm.**[1,3,4,6,7]



CLINICAL RESUL	
DISEASE ENTITY	
Acute back pain due to	
(a) Muscle spasm seconda to sprain	
(b) Muscle spasm due to trauma	
(c) Muscle spasm due to nerve irritation	
(d) Muscle spasm seconda to discogenic disease and postoperative orthopedic procedures	
Miscellaneous (bursitis, torticollis, etc.)	
TOTAL	

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ITH ROBAXIN IN ACUTE BACK PAIN[1,3,4,6,7]

. OF SES	DURATION OF TREATMENT	DOSE PER DAY (divided)	RESPONSE marked	mod.	slight	neg.	SIDE EFFECTS
3	2-42 days	3-6 Gm.	17	1	0	0	None, 16 Dizziness, 1 Slight nausea, 1
3	1-42 days	2-6 Gm.	8	1	3	1	None, 12 Nervousness, 1
5	4-240 days	2.25-6 Gm.	4	1	0	0	None, 5
9	2-28 days	1.5-9 Gm.	24	3	0	3	None, 25 Dizziness, 1 Lightheadedness, 2 Nausea, 2 *
5	3-60 days	4-8 Gm.	6	0	0	0	None, 6
2			59	6	3	4	*Relieved on reduction of dose

References: 1. Carpenter, E. B.: Publication pending. 2. Carter, C. H.: Personal communication. 3. Forsyth, H. F.: Publication pending. 4. Freund, J.: Personal communication. 5. Morgan, A. M., Truitt, E. B., Jr., and Little, J. M.: American Pharm. Assn. 46:374, 1957. 6. Nachman, H. M.: Personal communication. 7. O'Doherty, D.: Publication pending. 8. Truitt, E. B., Jr., and Little, J. M.: J. Pharm. & Exper. Therap. 119:161, 1957.

Indications – Acute back pain associated with: (a) muscle spasm secondary to sprain; (b) muscle spasm due to trauma; (c) muscle spasm due to nerve irritation; (d) muscle spasm secondary to discogenic disease and postoperative orthopedic procedures; and miscellaneous conditions, such as bursitis, fibrositis, torticollis, etc.

Dosage – Adults: Two tablets 4 times daily to 3 tablets every 4 hours. Total daily dosage: 4 to 9 Gm. in divided doses.

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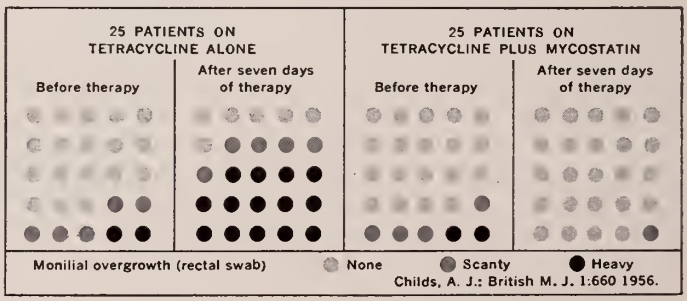

Childs, A. J.: British M. J. 1:660 1956.

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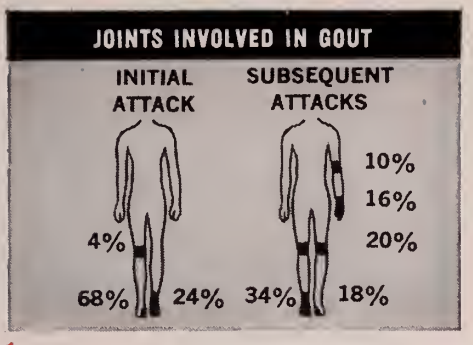

1. Recurrent joint pain followed by long periods of complete remission. *(Percentages refer to incidence.)*

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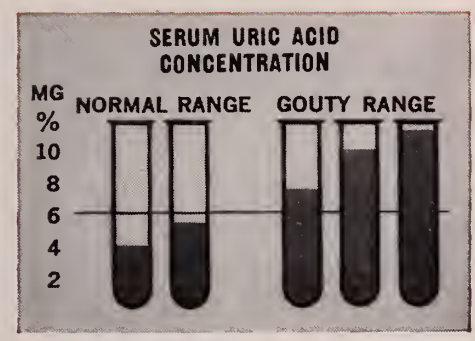

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*REFERENCE: J.A.M.A. 163: 359, 1957 (February 2)

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Subsequently	Breast or formula feeding	12-20 ml.

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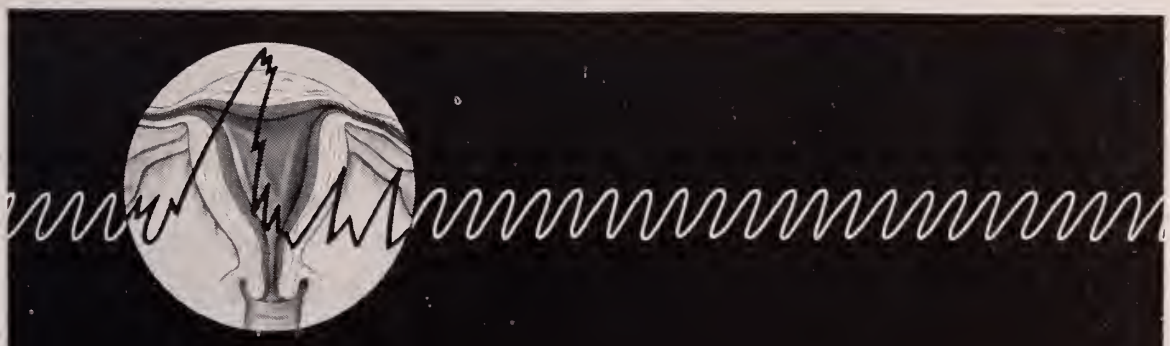

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How Old is Too Old for Tranquilizers ?

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When tranquilization seems risky . . .

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Yet even in the aged, ATARAX has given "no evidence of toxicity. . . . Complete liver function tests and blood studies were made on all patients after two months of therapy. . . . There were no significant abnormalities."* With still other elderly patients "tolerance to the drug was excellent, even in cases where the patients were given relatively high doses."* Similarly, no parkinsonian effects have been observed on ATARAX therapy.

Nor does ATARAX make your patients want to sleep all day. Instead, they can better take care of themselves, because ATARAX leaves them both calm and alert. In sum, ATARAX ". . . does not impair psychic function and has a minimum of side effects. . . . It appears that ATARAX is a safe drug. . . ."*

These, undoubtedly, are the results you want when emotional problems beset your geriatric patients. For the next four weeks, won't you prescribe tiny ATARAX tablets or pleasant-tasting ATARAX syrup — both so readily acceptable to the elderly.

*Documentation on request

ATARAX®
(BRAND OF HYDROXYZINE)

M. A. Seidel M.D.
Medical Director

New York 17, New York
Division, Chas. Pfizer & Co., Inc.

ATARAX

in any hyperemotive state

for childhood behavior disorders
10 mg. tablets—3-6 years, one tablet t.i.d.; over 6 years, two tablets t.i.d. Syrup—3-6 years, one tsp. t.i.d.; over 6 years, two tsp. t.i.d.

for adult tension and anxiety
25 mg. tablets—one tablet q.i.d. Syrup—one tbsp. q.i.d.

for severe emotional disturbances
100 mg. tablets—one tablet t.i.d.

for adult psychiatric and emotional emergencies
Parenteral Solution—25-50 mg. (1-2 cc.) intramuscularly, 3-4 times daily, at 4-hour intervals. Dosage for children under 12 not established.

Supplied: Tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

Meat...

and Protein Nutrition in Vascular Disease

Whether the eventual solution of the problem of atherogenesis will come out of the field of dietetics, biophysics, or pharmacology, one fact remains undeniable:

Adequate protein nutrition is considered of importance for the age group most commonly affected by disease of the vascular system, so that the demands of good nutritional health might be met.

Meat is outstanding among protein foods. It supplies all the essential amino acids, and closely approaches the quantitative proportions needed for biosynthesis of human tissue.

In addition, it is an excellent source of B vitamins, including B_6 and B_{12}, as well as iron, phosphorus, potassium, and magnesium.

When curtailment of fat intake is deemed indicated, meat need not always be denied the patient. Visible fat obviously should not be eaten. But the contained percentage of invisible (interstitial) fat is well within the limits of reasonable fat allowance.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion

American Meat Institute
Main Office, Chicago...Members Throughout the United States

REMARKABLE EFFECTIVENESS PLUS A SAFETY RECORD UNMATCHED IN SYSTEMIC ANTIBIOTIC THERAPY TODAY

Actually, after almost six years of extensive use, there has not been a single report of a serious reaction to ERYTHROCIN. And, after all this time, the incidence of resistance to ERYTHROCIN has remained exceptionally low.

You'll find ERYTHROCIN is highly effective against the majority of coccal infections and may also be used to counteract complications from severe viral attacks. It comes in *Filmtabs* and in Oral Suspension.

Abbott

802069

Compocillin-V®

for those penicillin-sensitive organisms

Indications

Against all penicillin-sensitive organisms. For prophylaxis and treatment of complications in viral conditions. And as a prophylaxis in rheumatic fever and in rheumatic heart disease.

Dosage

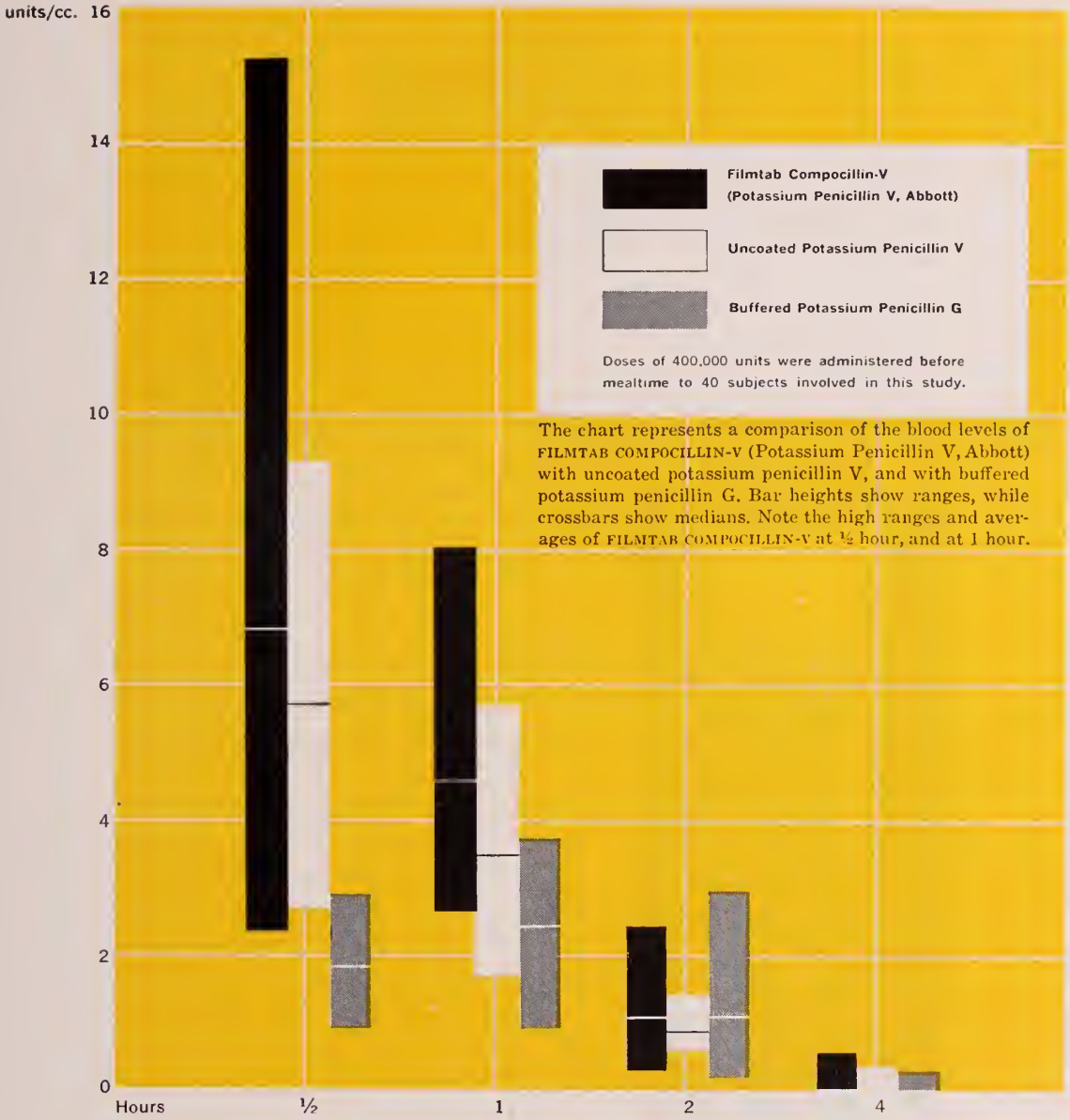
Depending on the severity of the infection, 125 to 250 mg. (200,000 to 400,000 units) every four to six hours. For children, dosage is determined by age and weight.

Supplied

Filmtabs COMPOCILLIN-V (Potassium Penicillin V, Abbott) come in 125 mg. (200,000 units), bottles of 50; and in 250 mg. (400,000 units), bottles of 25. Oral Suspension COMPOCILLIN-V (Hydrabamine Penicillin V, Abbott), contains 180 mg. per 5-cc. teaspoonful, in 40-cc. and 80-cc. bottles.

802071

THE HIGHER BLOOD LEVELS OF COMPOCILLIN-V
—IN EASY-TO-SWALLOW FILMTABS AND TASTY, ORAL SUSPENSION



Now, with *Filmtab* COMPOCILLIN-V, patients get (and within minutes) fast, high penicillin concentrations. Note the blood level chart.

COMPOCILLIN-V is indicated whenever penicillin therapy is desired. It comes in two highly-acceptable forms. *Filmtab* COMPOCILLIN-V offers two therapeutic dosages (125 and 250 mg.). Patients find *Filmtabs* tasteless, odorless and easy-to-swallow. For children, COMPOCILLIN-V comes in a tasty, banana-flavored suspension. It's ready-mixed – stays stable for at least 18 months.

Abbott

Spontin®

(Ristocetin, Abbott)

and when coccal infections hospitalize the patient

802070

Indications

SPONTIN is indicated for treating gram-positive bacterial infections. Clinical reports have indicated its effectiveness against a wide range of staphylococcal, streptococcal and pneumococcal infections. It can be considered a drug of choice for the immediate treatment of serious infections caused by organisms resistant to other antibiotics.

Dosage

Recommended dosage depends on the sensitivity of the microorganism and on the severity of the disease under treatment. For pneumococcal and streptococcal infections, a dosage of 25 mg./Kg. per day will usually be adequate. Majority of staphylococcal infections will be controlled by 25 to 50 mg./Kg. per day. However, in endocarditis due to relatively resistant strains or where vegetations or abscesses occur, dosages as high as 75 mg./Kg. per day may be used. It is recommended that the daily dosages be divided into two or three equal parts at eight- or twelve-hour intervals.

Supplied

SPONTIN is supplied as a sterile, lyophilized powder, in vials representing 500 mg. of ristocetin activity.

A LIFESAVING ANTIBIOTIC AFTER OTHER ANTIBIOTICS HAD FAILED

SPONTIN comes to the medical profession with a clinical history of dramatic results – cases where the patients were given little chance of survival.

During these careful, clinical investigations, lives were saved after weeks (and sometimes months) of antibiotic failures. These were the cases where the infecting organisms had become resistant to present-day therapy. And, just as important, were the good results found against a wide range of gram-positive coccal infections.

Essentially, SPONTIN is a drug for hospital use, for patients with potentially dangerous infections. In its present form, SPONTIN is administered intravenously using the drip technique. Dosage may be dissolved in 5% dextrose in water or in any isotonic or hypotonic saline solution. Some of the important therapeutic points of SPONTIN include:

1. successful short-term therapy for acute or subacute endocarditis
2. new antimicrobial activity – no natural resistance to SPONTIN was found in tests involving hundreds of coccal strains
3. antimicrobial action against which resistance is rare – and extremely difficult to induce
4. bactericidal action at effective therapeutic dosages.

SPONTIN is truly a lifesaving antibiotic. It could save the life of one of your patients – does your hospital have it stocked?

Abbott

new INCR with

CORRECTS IRON DEFICIENCY AS IT STIMULATES APPETITE

- Offers appetite stimulating Vitamins B_1, B_6, B_{12} and protein-upgrading l-Lysine, fortified with a readily absorbed, well-tolerated form of iron.
- Delicious cherry base designed to appeal to all patients.

PARTICULARLY FOR CHILDREN

Helps young appetites keep pace with the increased nutritional demands of childhood while supplying adequate amounts of essential iron.

EMIN* IRON SYRUP

LYSINE-VITAMINS

Provides the following percentages of Minimum Daily Requirements per teaspoonful:

	Child under 6	Child over 6	Adult
B_1	2000%	1333%	1000%
Iron	400%	300%	300%

FORMULA

EACH TEASPOONFUL (5 cc.) CONTAINS

l-Lysine HCl	300 mg.
Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
Vitamin B_{12} Crystalline	25 mcgm.
Thiamine Mononitrate (B_1)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Alcohol	0.75%

Average dosage is one teaspoonful daily. Available in bottles of 4 fl. oz.

*REG. U. S. PAT. OFF.

LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

Lederle

there's pain and inflammation here... it could be mild or severe, acute or chronic, primary or secondary fibrositis—or even early rheumatoid arthritis

more potent and comprehensive treatment than salicylate alone

. . . assured anti-inflammatory effect of low-dosage corticosteroid[1]

. . . additive antirheumatic action of corticosteroid plus salicylate[2-5] brings rapid pain relief; aids restoration of function.

. . . wide range of application including the entire fibrositis syndrome as well as early or mild rheumatoid arthritis

more manageable corticosteroid dosage

. . . much less likelihood of treatment-interrupting side effects[1-6]

. . . simple, flexible dosage schedule

in any case
it calls for

Sigmagen®

corticoid-salicylate compound tablets

Composition

METICORTEN® (prednisone)	0.75 mg.
Acetylsalicylic acid	325 mg.
Aluminum hydroxide	75 mg.
Ascorbic acid	20 mg.

Packaging: SIGMAGEN Tablets, bottles of 100 and 1000.

References: **1.** Spies, T. D., et al.: J.A.M.A. 159:645, 1955. **2.** Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. **3.** Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. **4.** Guerra, F.: Fed. Proc. 12:326, 1953. **5.** Busse, E. A.: Clin. Med. 2:1105, 1955. **6.** Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

Acute conditions: Two or three tablets four times daily. After desired response is obtained, gradually reduce daily dosage and then discontinue.

Subacute or chronic conditions: Initially as above. When satisfactory control is obtained, gradually reduce the daily dosage to minimum effective maintenance level. For best results administer after meals and at bedtime.

Precautions: Because SIGMAGEN contains prednisone, the same precautions and contraindications observed with this steroid apply also to the use of SIGMAGEN.

SCHERING CORPORATION • BLOOMFIELD, N. J.

SG-J-648

Schering

PMB-200

"Premarin" with Meprobamate new potency

Each tablet contains 0.4 mg. "Premarin," 200 mg. meprobamate

For undue emotional stress in the menopause

WRITE SIMPLY...

Also available as PMB-400 (0.4 mg. "Premarin," 400 mg. meprobamate in each tablet).

Supply:
No. 880, PMB-200 bottles of 60 and 500.
No. 881, PMB-400 bottles of 60 and 500.

AYERST LABORATORIES • New York 16, New York • Montreal, Canada

"Premarin®" conjugated estrogens (equine) Meprobamate licensed under U.S. Pat. No. 2,724,720 5830

WISCONSIN NEUROLOGICAL FOUNDATION

1954 East Washington Avenue
Madison, Wisconsin

A treatment and rehabilitation center providing inpatient and outpatient services for those disabled as a result of neurological disorders.

Diagnostic Studies	Occupational Therapy
Physical Medicine	Vocational Counseling
Speech Therapy	Therapeutic Recreation

If Monilial overgrowth is a factor

Achrostatin* V

TETRACYCLINE (PHOSPHATE-BUFFERED) AND NYSTATIN

Combines ACHROMYCIN V with NYSTATIN

SUPPLIED:

CAPSULES contain 250 mg. tetracycline HCl equivalent (phosphate-buffered) and 250,000 units Nystatin. ORAL SUSPENSION (cherry-mint flavored) Each 5 cc. teaspoonful contains 125 mg. tetracycline HCl equivalent (phosphate-buffered) and 125,000 units Nystatin.

DOSAGE:

Basic oral dosage (6-7 mg. per lb. body weight per day) in the average adult is 4 capsules or 8 tsp. of ACHROSTATIN V per day, equivalent to 1 Gm. of ACHROMYCIN V.

ACHROSTATIN V combines ACHROMYCIN† V ...the new rapid-acting oral form of ACHROMYCIN† Tetracycline...noted for its outstanding effectiveness against more than 50 different infections ...and NYSTATIN...the antifungal specific. ACHROSTATIN V provides particularly effective therapy for those patients prone to monilial overgrowth during a protracted course of antibiotic treatment.

LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, N. Y.

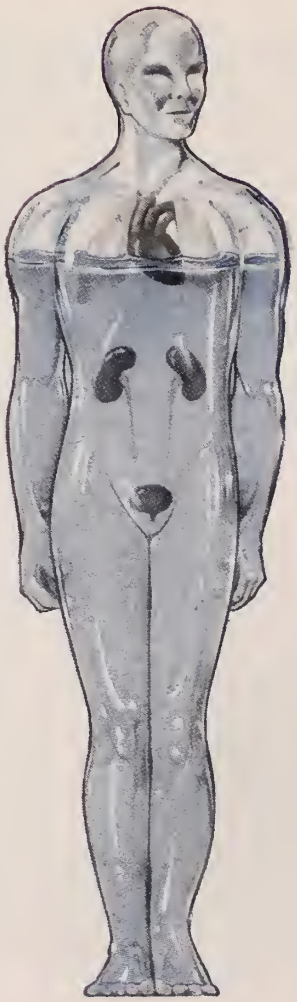
*Trademark †Reg. U. S. Pat. Off.

'DIURIL'

(CHLOROTHIAZIDE)

in

EDEMA



Start therapy with one or two 500 mg. tablets of 'DIURIL' once or twice a day.

BENEFITS:

- The only orally effective nonmercurial agent with diuretic activity equivalent to that of the parenteral mercurials.
- Excellent for initiating diuresis and maintaining the edema-free state for prolonged periods.
- Promotes balanced excretion of sodium and chloride—without acidosis.

Any indication for diuresis is an indication for 'DIURIL':

Congestive heart failure of all degrees of severity; premenstrual syndrome (edema); edema and toxemia of pregnancy; renal edema—nephrosis; nephritis; cirrhosis with ascites; drug-induced edema. May be of value to relieve fluid retention complicating obesity.

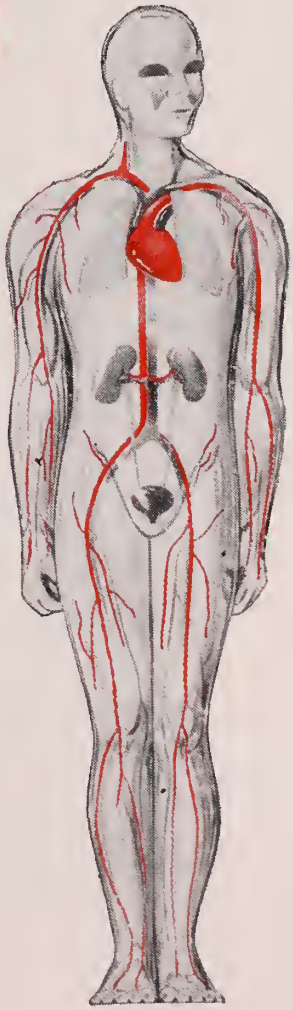
SUPPLIED: 250 mg. and 500 mg. scored tablets 'DIURIL' (chlorothiazide); bottles of 100 and 1,000.

'DIURIL' and 'INVERSINE' are trade-marks of Merck & Co., Inc.

MSD MERCK SHARP & DOHME
Division of MERCK & CO., INC., Philadelphia 1, Pa.

as simple
as 1-2-3
in

HYPERTENSION



1 INITIATE 'DIURIL' THERAPY

'DIURIL' is given in a dosage range of from 250 mg. twice a day to 500 mg. three times a day.

2 ADJUST DOSAGE OF OTHER AGENTS

The dosage of other antihypertensive medication (reserpine, hydralazine, etc.) is adjusted as indicated by patient response. If the patient is established on a ganglionic blocking agent (e.g., 'INVERSINE') this should be continued, but the total daily dose should be *immediately* reduced by 25 to 50 per cent. This will reduce the serious side effects often observed with ganglionic blockade

3 ADJUST DOSAGE OF ALL MEDICATION

The patient must be frequently observed and careful adjustment of all agents should be made to determine optimal maintenance dosage.

BENEFITS:

- improves and simplifies the management of hypertension
- markedly enhances the effects of antihypertensive agents
- reduces dosage requirements for other antihypertensive agents—often below the level of distressing side effects
- smooths out blood pressure fluctuations

INDICATIONS: management of hypertension

Smooth, more trouble-free management of hypertension with 'DIURIL'

How to provide unsaturated fatty acids without dieting

With type as well as amount of fat in the human diet now assuming such importance, the new role of corn oil as a source of unsaturated fatty acids has prompted these questions:

1 What is the role of unsaturated fats in the daily diet?

answer: There is now ample clinical evidence that unsaturated fats tend to lower the serum cholesterol level of human subjects, whereas saturated fats have the opposite effect.

2 How much of the important unsaturated fatty acids does corn oil provide?

answer: MAZOLA Corn Oil yields an average of 85 per cent unsaturated fatty acids. 100 grams of MAZOLA will yield: 53 grams of linoleic acid and 28 grams of oleic acid; it also provides 1.5 grams of sitosterols, and only 12 grams of saturated fatty acids.

3 What is the best way to provide unsaturated fatty acids?

answer: By balancing the types of fat in the daily diet. Many doctors now agree that from one third to one half of the total fat intake should be in the form of a vegetable oil such as corn oil (MAZOLA).

4 How is corn oil most easily taken in the usual daily diet?

answer: There is no need to disturb the daily routine of meals or to have separate diets for individual members of the family. MAZOLA Corn Oil can be used instead of solid fats in preparing and cooking foods, it is also ideal for salad dressings.

5 How can I obtain further information on the value of corn oil as a source of unsaturated fatty acids?

answer: The subject is reviewed in the book "Vegetable Oils in Nutrition." Also available is a recipe book for distribution to your patients. It tells how to use corn oil in everyday meals. Both books will be sent free of charge to physicians, on request.

CORN PRODUCTS REFINING COMPANY
17 Battery Place, New York 4, N.Y.

for simultaneously combating inflammation, allergy, infection

(0.5% prednisolone acetate and 10% sulfacetamide sodium—5 cc. dropper bottle)

(0.5% prednisolone acetate, 10% sulfacetamide sodium and 0.25% neomycin sulfate—⅛ oz. tube)

in external eye disorders look to these topical healing aids

for ocular allergies

METRETON
ophthalmic suspension

(0.2% prednisolone acetate and 0.3% CHLOR-TRIMETON®—5 cc. dropper bottle)

standard for ocular infections

Sodium SULAMYD

(Sulfacetamide Sodium U.S.P.—5 and 15 cc. dropper bottles)

Sodium SULAMYD

(15 cc. dropper bottle)

Sodium SULAMYD

(⅛ oz. tube)

SCHERING CORPORATION • BLOOMFIELD, NEW JERSEY

Schering

M-J-128

The non-narcotic analgesic with the potency of codeine

DARVON (Dextro Propoxyphene Hydrochloride, Lilly) is equally as potent as codeine yet is much better tolerated. Side-effects, such as nausea or constipation, are minimal. You will find 'Darvon' helpful in any condition associated with pain. The usual adult dose is 32 mg. every four hours or 65 mg. every six hours as needed. Available in 32 and 65-mg. pulvules.

DARVON COMPOUND (Dextro Propoxyphene and Acetylsalicylic Acid Compound, Lilly) combines the antipyretic and anti-inflammatory benefits of 'A.S.A. Compound'* with the analgesic properties of 'Darvon.' Thus, it is useful in relieving pain associated with recurrent or chronic disease, such as neuralgia, neuritis, or arthritis, as well as acute pain of traumatic origin. The usual adult dose is 1 or 2 pulvules every six hours as needed.

Each Pulvule 'Darvon Compound' provides:

'Darvon'	*32 mg.*
Acetophenetidin	*162 mg.*
'A.S.A.' (Acetylsalicylic Acid, Lilly)	*227 mg.*
Caffeine	*32.4 mg.*

*'A.S.A. Compound' (Acetylsalicylic Acid and Acetophenetidin Compound, Lilly)

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U. S. A.

820260

EFFECTIVE, DEPENDABLE THERAPY FOR VAGINITIS

Floraquin® eliminates trichomonal and mycotic infection; restores normal vaginal acidity

Leukorrhea is by far the most frequent symptom of vaginitis; trichomonads and monilia are the most common causes. Many authors have reported[2] trichomonal protozoa in the vagina of 25 per cent of obstetric and gynecologic patients. Increased use of broad spectrum antibiotics has resulted in a sharp rise in the incidence of monilial infections.

Floraquin effectively eradicates both trichomonal and monilial vaginal infections through the action of its Diodoquin® content. Floraquin also furnishes boric acid and sugar to restore the normal vaginal acidity which inhibits pathogens and favors the growth of protective Döderlein bacilli.

Pitt[1] recommends vaginal insufflation of Floraquin powder daily for three to five days, followed by acid douches and the daily insertion of Floraquin vaginal tablets throughout one or two menstrual cycles. G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

1. Pitt, M. B.: Leukorrhea. Causes and Management, J. M. A. Alabama *25*:182 (Feb.) 1956.
2. Parker, R. T.; Jones, C. P., and Thomas, W. L.: Pruritus Vulvae, North Carolina M. J. *16*:570 (Dec.) 1955.

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"THE DOCTORS' PLAN"

THE BLUE SHIELD PLAN
OF THE
STATE MEDICAL SOCIETY OF WISCONSIN

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Write: P. O. Box 1109, MADISON, WIS.

Phone: ALpine 6–3101, MADISON, WIS.

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Volume 57 MARCH 1958 Number 3

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Doctors' Report Card

For those who are interested, the A.M.A.'s 1957 nation-wide survey on county medical society activities provides a yardstick of progress. How does your society measure up to this report on 985 other county societies:

Regular Meetings—Three-fourths of the societies prefer monthly meetings.

Type of Program—There is growing interest in socio-economic programs, but most societies, large or small, feature scientific material. Topics that draw the best have well-known speakers and have associated dinners or social programs. Topics that draw least are highly specialized philosophical topics and theoretical science.

Attendance—Most societies report more than 50 percent of their membership attending on an average. What's more, attendance is on the increase.

Committees—The most prevalent are those concerned with public relations and public service, legislation, civil defense, public health, professional relations, and school health.

Emergency Call Plans—More than half the county societies report formal plans for answering emergency calls. The remainder, mostly smaller societies, report informal arrangements working satisfactorily.

Participation on Official Boards—A majority of the societies, and sometimes a majority of individual members, are reported as participating in civic and governmental bodies such as school boards, health departments, public welfare boards, and other governmental posts.

These are but a few excerpts from an interesting document which might be called the doctors' report card. It is a progress chart of the programs sponsored by the county medical societies of the nation to help bring better medical care to the people. Medicine apparently rates an "A" for achievement, but like most report cards this one contains a footnote reading: "You can do still better."

A Notable Edition

The first special edition of *The Journal of the American Medical Association*, published on February 15, 1958, is truly a notable achievement. Moreover, it has special significance for Wisconsin.

This 117-page issue, a guide to the evaluation of permanent impairment of the extremities and back, was prepared by a committee on medical rating of

physical impairment which included Dr. O. A. Sander of Milwaukee. His participation is all the more noteworthy since it continues a tradition of Wisconsin leadership in the field of industrial health and workmen's compensation.

The guide is an important medical document because it provides authoritative material on the scope of medical responsibility in evaluation of permanent disability and the difference between "permanent disability" and "permanent impairment."

Physicians everywhere will do well to file this edition for future reference.

CHIROPRACTIC

Mr. Wisconsin Citizen, take note:

U. S. Attorney George E. Rapp Tuesday filed a condemnation suit in Madison Federal Court against nine devices labeled as capable of measuring "nerve interference."

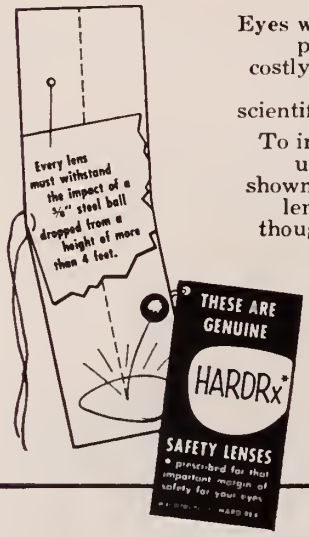
The devices are in the possession of I. N. Toftness, a Cumberland (Barron County) chiropractor, the suit charges.

Rapp's suit declares that the instruments were shipped from Elecronic Instrument, Inc. of Tiffin, Ohio to Cumberland between November 27, 1956 and July 25, 1957, and were "misbranded while held for sale after shipment in interstate commerce."—From: *Wisconsin State Journal*, January 15, 1958.

Perhaps this device could measure the amount of "nerve" demonstrated by the Toftness group when it pleaded with the legislature last year for state recognition of chiropractic's "professional status" and "scientific acumen" in the treatment of workmen's compensation and public assistance cases!

make protection a part of every prescription

PRESCRIBE BENSON'S HARDRx SAFETY LENSES!



Eyes worth correcting are worth protecting. All of your patients *deserve* maximum safety from dangerous and costly lens breakage. Benson's HARDRx safety lenses — ground to a formula-determined thickness and scientifically heat-treated — are toughened to resist impact.

To impress on your patients that you've prescribed the ultimate in lenses for them, the identifying tag shown at left is attached to each pair of genuine HARDRx lenses. Your patients will appreciate your thoughtfulness in prescribing this extra protection . . . and will tell their friends of your quality service.

Join the growing number of doctors who specify HARDRx regularly. Remember: HARDRx prescriptions receive the same prompt handling.

1913-1958 . . . Our 45th year

Executive Offices
Minneapolis 2, Minn.

Benson OPTICAL COMPANY

BVI

Laboratories Serving Wisconsin: **Beloit, Eau Claire, La Crosse, Stevens Point, Superior and Wausau, Wis.; and Duluth, Minn.**

Society Proceedings*

Barron–Washburn–Sawyer–Burnett

A buffet dinner sponsored by the Woman's Auxiliary was given at the Rice Lake home of *Dr. D. G. MacMillan* for the December 10 meeting of the Barron–Washburn–Sawyer–Burnett County Medical Society. Proceeds from the dinner were applied to the Auxiliary's nursing scholarship fund.

Following the dinner the annual elections were held. *Dr. C. J. Strang*, Barron, assumed the office of president, *Dr. D. G. MacMillan* was named vice-president, and *Dr. H. M. Templeton*, Barron, was re-elected secretary.

Brown

Dr. William M. Engstrom, Milwaukee, was the guest speaker at the January 9 meeting of the Brown County Medical Society, held at the Green Bay Elks Club. An associate professor of medicine at Marquette University School of Medicine, Doctor Engstrom addressed the group on "Some Problems in Graves' Disease."

Calumet

Members of the professional staff of Calumet Memorial Hospital were guests of the Calumet County Medical Society when its members and their wives enjoyed a Christmas dinner and party on December 22. The professional staff presented the doctors with miscellaneous personal trinkets and a radio, which will be placed in the staff room of the hospital. Co-chairmen of the event were *Dr. Kenneth Humke* of Chilton and *Dr. F. P. Larme* of New Holstein.

Eau Claire–Dunn–Pepin

A special meeting of the Eau Claire–Dunn–Pepin County Medical Society was held on January 6 at the Sacred Heart Hospital in Eau Claire to discuss plans for training a cytologist. A motion was passed that a woman would be sent to *Dr. W. D. Stovall's* laboratory in Madison for a six-month period to prepare her for screening cervical smears for cancer under the supervision of local pathologists.

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Green

Senator Robert S. Travis of Platteville, of the seventeenth senatorial district of the State of Wisconsin, was the guest speaker at the February 4 meeting of the Green County Medical Society. "Procedures of the Wisconsin Senate" was the title of the senator's talk. Wives of the society members were guests at this dinner meeting held at the Monroe Country Club.

Lafayette

Dr. R. E. Hunter, Argyle, took over the post of president at the January 17 meeting of the Lafayette County Medical Society. Other officers elected were: *Drs. D. L. Garland*, Shullsburg, vice-president; *N. A. McGreane*, Darlington, secretary–treasurer; *L. L. Olson*, Darlington, delegate; and *Doctor Garland*, alternate

Marathon

Thirty-five members of the Marathon County Medical Society met January 27 at the Wausau Club. A report was presented by *Dr. Marvin Olson* on the pending weekly TV programs sponsored jointly by the local TV station and the Marathon County Society.

Outagamie

Dr. P. M. Cunningham presented a program on the five years work of the Outagamie County Cancer Society at the meeting of the Outagamie County Medical Society held January 16 at the Elks Club in Appleton. A panel composed of *Drs. J. P. Skibba, G. W. Carlson and P. M. Cunningham* discussed the establishment of a cytologic screening center.

It was announced during the business session that an effort is being made to determine why persons are clothed while having films taken in mobile x-ray units. The subject of group insurance was also considered.

Pierce–St. Croix

At the January 21 meeting of the Pierce–St. Croix County Medical Society the guest speaker was Dr. William Mazzitello of the University of Minnesota. He addressed the group on "Newer Concepts and Treatment of Heart Disease."

Polk

Twenty-one members of the Polk County Medical Society were dinner guests of *Dr. L. O. Simenstad* at the Dalles House, St. Croix Falls, on January 16. A round-table discussion on social economic problems was held.

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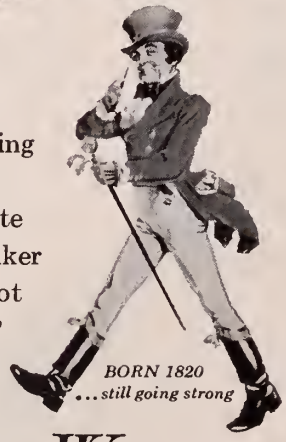

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Richland

Dr. B. M. Peckham, professor and chairman of the department of obstetrics and gynecology, University of Wisconsin Medical School, lectured on uterine bleeding at the January 23 meeting of the Richland County Medical Society held at the Richland Hospital Library. Twelve members were present.

Shawano

The Shawano County Medical Society met January 15 at the Shawano Municipal Hospital. They elected the following officers for 1958:

President—*Dr. L. W. Peterson*
Vice-President—*Dr. David Arvold*
Secretary–Treasurer—*Dr. A. J. Sebesta*
Delegate—*Dr. H. C. Marsh*
Alternate—*Dr. D. A. Jeffries*

Dr. R. J. Toll was elected to the Board of Censors, and *Dr. H. C. Marsh* was named representative to the Board of Trustees of the Charitable, Educational, and Scientific Foundation of the State Medical Society.

Dr. R. C. Cantwell, Shawano, presented the scientific portion of this meeting.

Trempealeau–Jackson–Buffalo

On January 28 the Trempealeau–Jackson–Buffalo County Medical Society held its monthly meeting at the hotel in Fountain City. The events of the evening consisted of a talk by a representative of the American Cancer Society and a business meeting concerning a minimum fee schedule.

Walworth

"Farmers' Lung" was the topic chosen by Dr. John Rankin when he addressed the Walworth County Medical Society December 12 at the Sterlingworth Hotel in Elkhorn. Doctor Rankin is an assistant professor of medicine at the University of Wisconsin Medical School. Also present at the meeting was *Dr. W. D. Stovall,* Madison, who spoke to the group on the proposed medical museum.

Following the talks the members elected *Dr. Joseph Schrock,* Sharon, president; *Dr. George Truex,* Darien, vice-president; and *Dr. Wm. Woods,* Delavan, secretary–treasurer.

On January 15 the society heard *Dr. B. M. Peckham,* professor and chairman of the department of obstetrics at the University of Wisconsin Medical School, speak on endometriosis at their meeting held at the Colonial Hotel in Delavan. A public relations committee was appointed during the business session.

Washington–Ozaukee

The Washington-Ozaukee County Medical Society held a meeting at the Kewaskum Republican Hotel on January 30. A Spanish exchange student at Port Washington High School, Miss Maria Garcia, gave her impressions of America and described her life in Spain to the 37 doctors and wives present.

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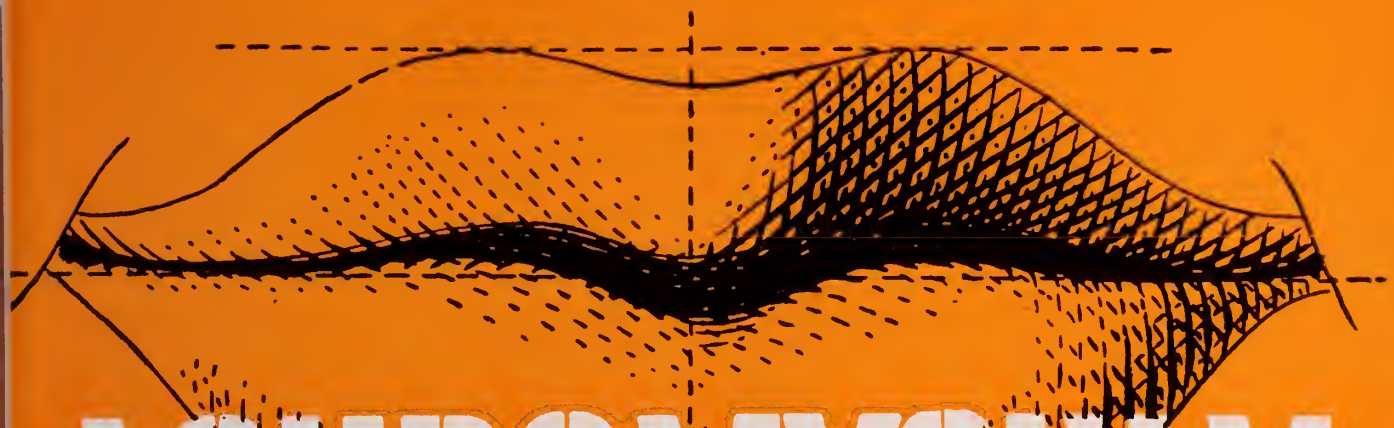

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- accelerated absorption in the gastro-intestinal tract
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ACHROMYCIN V SYRUP:
Orange Flavor. Each teaspoonful (5 cc.) contains 125 mg. of tetracycline, HCl equivalent, citrate-buffered. Bottles of 2 and 16 fl. oz.

DOSAGE:
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The members made initial plans for sponsoring mass tuberculin skin testing in Washington and Ozaukee counties, with emphasis on school children and contacts of known cases.

Winnebago

Members of the Winnebago County Medical Society heard a talk on "Geriatric Backache" when they met on January 9 at the Hotel Menasha. The speaker was *Dr. R. C. Brown*, a Neenah physician. *Dr. L. D. Graber*, Oshkosh, is the program chairman of the society.

Wood

On January 23, members of the Wood County Medical Society met at the Casa Loma, Marshfield. *Dr. John E. Thompson* of Nekoosa presented a paper on "Gas Gangrene."

Election of officers for 1958 was the main business of the evening. Those elected were: *Drs. W. L. Nelson*, Wisconsin Rapids, president; *G. S. Custer, Jr.*, Marshfield, vice-president; *J. R. Heersma*, Marshfield, secretary–treasurer; *R. J. Rowe* of Marshfield, *C. J. Arendt* of Wisconsin Rapids and *P. F. Doege* of Marshfield, censors.

Milwaukee Neuro-Psychiatric Society

The Milwaukee Neuro-Psychiatric Society met at the University Club of Milwaukee on January 15 for a business meeting, dinner, and scientific session. Guest speaker on the program was Dr. Russell Meyers, professor of surgery and chairman of the division of neurosurgery at the State University of Iowa. Doctor Meyers spoke on "The Pathophysiology and Surgical Therapy of the Hyperkinetic-Dystonic Disorders."

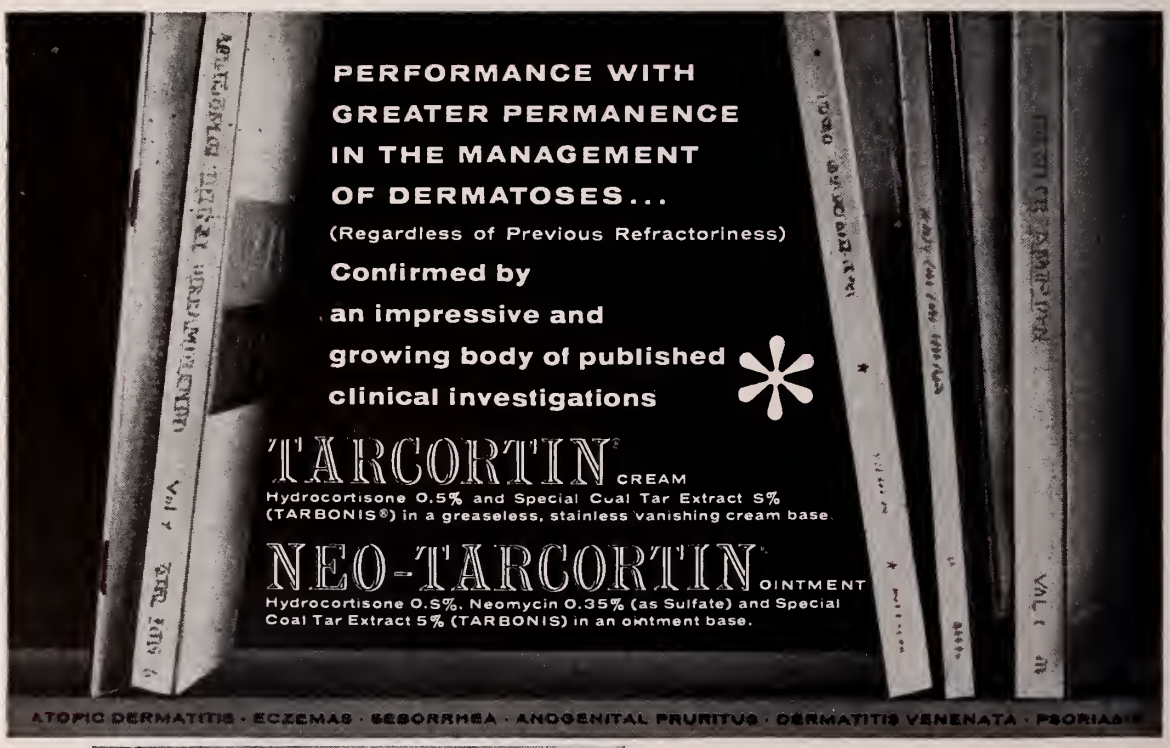
Milwaukee Urological Society

At the recent annual meeting of the Milwaukee Urological Society *Dr. James W. Sargent* was elected president. The office of secretary–treasurer will be filled by *Dr. John D. Silbar*.

Wisconsin Radiological Society

The following officers were elected at the annual fall meeting of the Wisconsin Radiological Society:

President: *William W. Moir*, Sheboygan
President-Elect: *S. R. Beatty, Neenah*
Secretary–Treasurer: *Farrell F. Golden*, Madison



* J.A.M.A. *166*:158,1958; Welsh,A.L. and Ede,M. "*...prompt remissions of...acute phases.*" with TARCORTIN

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5. Bleiberg, J.: Am. Practitioner *8*:1404, 1957.

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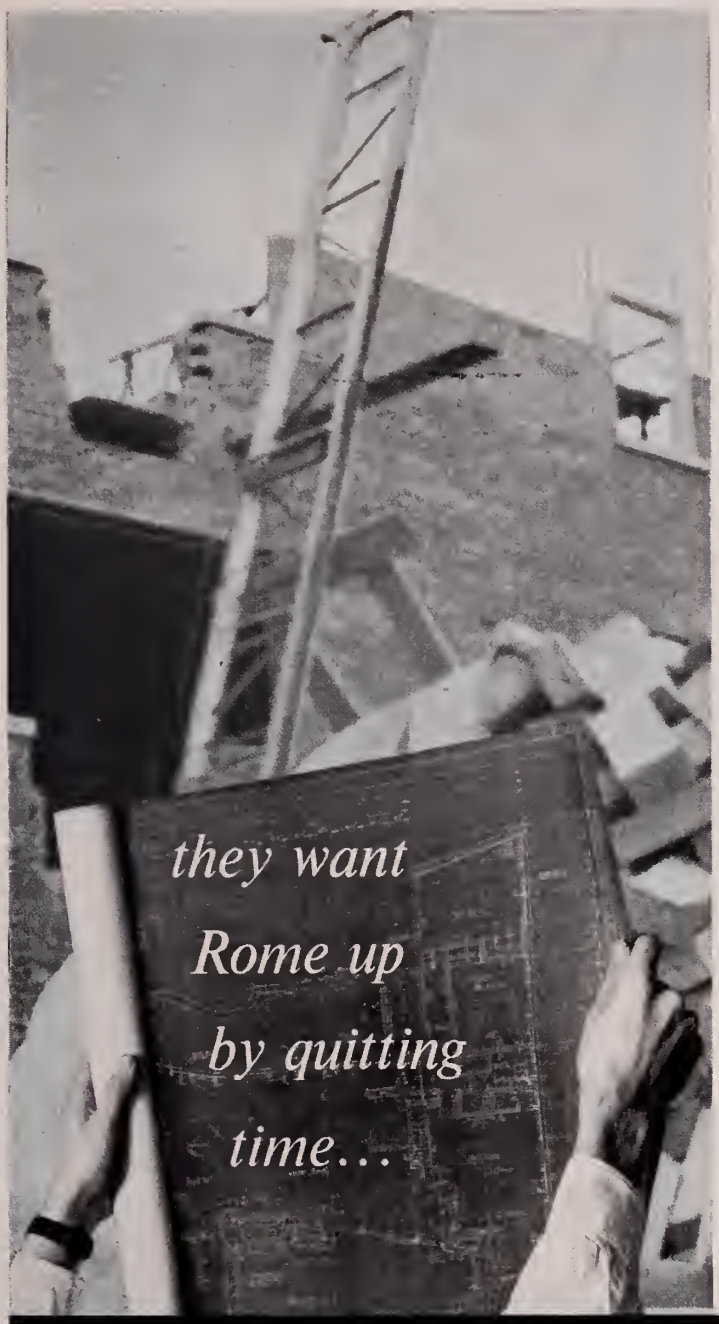

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1 Comparative Effects of Various Rauwolfia Alkaloids in Hypertension; *Diseases of the Chest*, in press.

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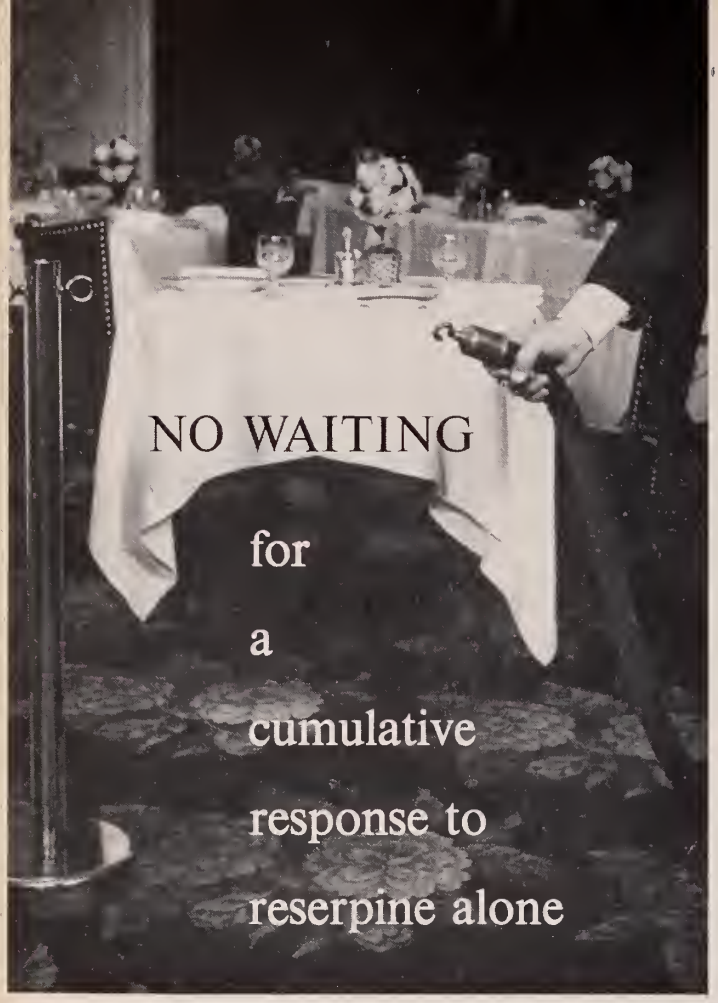

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Milwaukee Academy of Medicine

Dr. Howard J. Lee took office as president of the Milwaukee Academy of Medicine at its annual dinner meeting held on January 21 at the University Club. *Dr. James E. Conley* was named president-elect to become president a year from now. Among other officers selected were *Drs. Paul F. Hausmann*, vice-president; *George C. Owen*, secretary; *David W. Ovitt*, treasurer, and *Francis F. Rosenbaum*, librarian. *Dr. Paul G. LaBissoniere* was named to the membership committee and Richard S. Falk, secretary and assistant to the president of the Falk Corporation, was elected trustee of the Academy to succeed his father, the late Harold S. Falk. It was also announced that *Drs. Timothy J. Howard* and *John R. Dundon* had been made honorary members of the Academy.

Wisconsin Medical Alumni Association

Some 60 members of the Wisconsin Medical Alumni Association attended the group's fall meeting held at the University of Wisconsin Medical School on October 26. The organization, formed last year, will meet in the spring and fall of each year, according to *Dr. Einar R. Daniels*, Milwaukee, president.

Among the medical school faculty members who reported on research projects were Drs. Nathan J. Smith, *Herman W. Wirka*, *Halvor Vermund*, and David T. Graham.

At the same meeting, the following physicians were named Associates: *Drs. H. J. McLane*, Fond du Lac; *J. A. Beyer*, Madison; *D. B. Becker, Jr.*, Oshkosh; *R. J. Mayer*, Racine; *J. F. Hildebrand*, Sheboygan, and *R. C. Meade*, Wood.

THIRD AND TWELFTH DISTRICT NEWS

Doctor Engstrom Named to New Post

Dr. William W. Engstrom, an associate professor of medicine at the Marquette University School of Medicine, has been appointed assistant director of medicine at the Milwaukee County General Hospital on a temporary basis. He was named to succeed Dr. Edwin G. Olmstead, who resigned.

Doctor Engstrom is director of the metabolic clinic and laboratory at the hospital.

Postgraduate Course on Malignant Disease

Malignant disease was the subject of a postgraduate medicine course at the University of Wisconsin Medical School in January.

Chairman of the course was Dr. Anthony R. Curreri, director of the university's cancer research hospital and professor of surgery. Guest lecturers included Dr. Forde McIver, of the Medical College of South Carolina, Charleston, and Dr. George Moore, director and chief of surgery, Rosewell Park Memorial Institute, Buffalo, N. Y.

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the cough

the aching muscles

the fever

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THE MEDICAL FORUM

Memorial Gifts? Doctors' Own Foundation Offers Opportunity!

MADISON—The Charitable, Educational and Scientific Foundation of the State Medical Society looks to both physician and the public for contributions, vital to the success of an array of projects.

As is generally known, the doctor is solicited annually. He may make his contribution by a yearly donation at the time of solicitation, or through a will, a commemorative gift, or a carefully directed and earmarked offering.

Extremely important is the great opportunity for the physician to advise and encourage laymen—patients and friends—who are considering memorial gifts to direct those gifts to the foundation. The doctor's family, of course, may make gifts in his honor, too. And one such, of $10,000, made a few months ago, is a huge help to the foundation's student loan fund.

The M.D. can assure the potential donor that gifts will be earmarked for special purposes, but that unspecified contributions always will be used for worthy educational, charitable, or research projects in the medical field.

DONATIONS ARE DEDUCTIBLE

They may be earmarked for use by the foundation in the Medical Museum of Wisconsin, being constructed at Prairie du Chien. Or for a special research project, such as the one on hearing loss and inhalation therapy.

These memorial gifts, which do so much to keep alive the memory of friends and relatives, are tax deductible. Donations to the foundation are now considered as "donations and contributions" within the terms of income tax regulations, and thus may be deducted on personal income tax reports.

Continued tax-exempt status for the foundation depends on the ability of the society to demonstrate its activities are truly of a non-profit, charitable, educational and scientific nature.

In its first three years of existence, nearly $53,400 was contributed to the foundation for various efforts and programs, exclusive of the museum campaign. The foundation is still quite young, and possibilities for true scientific and educational achievements are almost boundless.

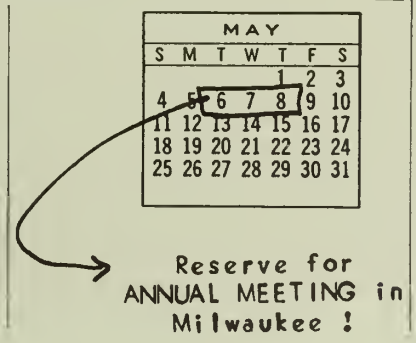
Wisconsin physicians have now, for the first time, an organization of their own in which they may channel financial and other assistance for special worthy purposes wholly under the direction of the profession.

The foundation was created to serve the society membership as a constant companion to the physician's thoughts of charity, sympathy and philanthropy.

Dr. Heidner Named Head of Commission

MILWAUKEE—Dr. A. H. Heidner, West Bend, was recently reelected chairman of the Wisconsin Commission for the Improvement of Patient Care.

Edward Logan, Milwaukee, of the Wisconsin Hospital Association, was named vice chairman, and Earl R. Thayer, Madison, of the State Medical Society, secretary.



Re-Name Arveson Council Chairman

MADISON—Dr. R. G. Arveson, of Frederic, was reelected chairman of the Council of the State Medical Society recently.

Other officers, also reelected:

Dr. F. L. Weston, Madison, treasurer: Drs. H. Kent Tenney and N. A. Hill, Madison, assistant treasurers; Dr. J. M. Sullivan, Milwaukee, editorial director of *The Wisconsin Medical Journal;* Dr. R. S. Baldwin, Marshfield, medical director of the *Journal*, and C. H. Crownhart, Madison, secretary.

A new program of post-graduate teaching for doctors was launched in March by the society.

At its annual meeting, the society's Council voted to schedule a series of four one-day meetings in each of two hospitals, not yet selected.

Physicians from the University of Wisconsin and Marquette University will work personally with all doctors attending. The Council said the idea of its new "hospital staff teaching service" would be "more personal" teaching than the lecture-type post-graduate instruction used in the past.

The Council adopted a statement on ethical principles involving the association of ancillary personnel in a physician's practice. The term "ancillary personnel" includes those engaged in podiatry, physical therapy, optometry, clinical psychology and others.

Generally the practice of designating such individuals on letterheads, professional announcements or in physicians' offices is unethical because it creates an impression that these individuals have professional equivalency to the physician. The employment of such individuals for the purpose of utilizing their training under physician direction for patient care is not per se unethical.

A return to a fall date for the Annual Meeting of the State Medical Society at the earliest practicable time was authorized by the Council.

The Council approved recent contract negotiations continuing the society's operation of the Medicare program in Wisconsin.

IS YOUR PENSION HEADED FOR TROUBLE?.....

Bigger pensions for the aged, and for workers' survivors, are being talked up in Congress. New benefits also are planned.

The problem is how to pay for all these added benefits.

The Social Security System already is paying out more money than it takes in, and will for two more years.

All this could put a damper on a drive for higher pensions.

Serious questions now are being raised about the future soundness of the Social Security program that promises old-age pensions and survivor benefits to nearly every family in America.

The reason for these fresh doubts about the retirement system is that new raises in pensions are being planned in Congress just at the time when the pension-reserve fund is running into its first deficit in history.

Government officials—as well as many of the more than 10 million people now drawing Social Security checks—are asking questions such as these: Will Congress adopt another expensive raise in benefits? If it does, where will the money come from? From payroll taxes? From general taxes? Or from the reserve fund? What will happen to the pension fund?

The problem. To understand such concern, you need to note two significant points—the way Congress has of sweetening pensions in election years, and the tax schedule already in law for payment of these pensions.

The record shows clearly that Congress likes to raise pensions in election years. Not since 1948, in fact, has Congress failed to liberalize Social Security in an election year.

In this election year of 1958, however, Congress faces the fact that the Social Security payroll tax now is set for a rising schedule that is about as stiff as anybody ever imagined it could be.

Already a worker and his employer split a 4½ per cent tax on the first $4,200 that the worker earns in a year. Each pays $94.50 a year on $4,200. What many workers and employers do not realize is that this payroll tax already is scheduled in law to rise gradually to a top of 8½ per cent in 1975.

Even without any further changes in law, then, the worker and his employer each will be required later on to pay as much as $178.50 a year. And the self-employed lawyer or other professional person or businessman will pay a top tax of $267.75 a year.

These tax figures include the payroll tax that finances the program under which workers are protected against disability. They do not include, however, the additional tax that employers pay in order to provide unemployment checks for workers.

Government officials and some members of Congress are wondering whether the schedule of Social Security taxes might not be about as steep as is safe, or as steep as the country will approve. They're wondering, too, what will happen to the old-age system if Congress raises benefits but ducks the question of future expense.

NOTE!

This article, of paramount interest to every physician, is reprinted in the Medical Forum from the *U.S. News and World Report*, an independent weekly news magazine published at Washington. Copyright 1958 United States News Publishing Corporation. Date of issue was January 17, 1958.

Costs: up and up. In this election year, the first reserve-fund deficit is likely to bring home to Congress the enormous cost of boosting pensions.

At this time, Government actuaries are taking a new look at the Social Security System to determine what is happening to its income, its outgo and its 22-billion-dollar fund. Their findings, nearly complete, emphasize the costliness of pension increases.

Before 1950, pension costs were rising slowly and steadily, as the program began to mature. Then, after changes made in 1950, pension payments nearly doubled in just one year.

After changes in 1952, the flow than 2.2 billion dollars to more than 3 billion in 1953—a jump of 37 per cent in one year.

Similar cost increases followed the 1954 and 1956 amendments. It has been only two years since pension coverage last was broadened, but costs this year will be a whopping 8 billions, 2.3 billions more than in 1956.

These cost increases, moreover, have a way of turning out bigger than anybody expects at the time pension increases are considered.

Trends that followed the increases adopted in 1956 offer an example. The highest of the official estimates made in 1956 indicated that benefit costs in 1960 would come to 8.6 billion dollars. Now 8.9 billion looks like a more accurate figure.

The most pessimistic of the official estimates in 1956 put the pension-reserve fund at 24.5 billion dollars at the end of 1960. The most optimistic estimate pointed to 27.3 billion as the figure. Now the prospect is for a fund of just 21.8 billion at the end of 1960.

A part of this unexpected rise in costs has been the result of developments that will be at least partially offset later on. Still, some of the unexpected rise was real.

The shrinking fund. There is the hard fact, too, that the big reserve fund is declining, and will be for two more years before the next tax increase can start it growing again. This is the prospect even without any new moves to increase retirement pay.

All this helps explain why new plans to boost pensions are raising the question of whether at some time in the future the big reserve fund will be allowed to disappear.

This, actually, is what officials predict will happen if Congress grants higher benefits without raising the payroll tax. The only other possibility would be to nourish the program with funds from general revenues — which means largely from income taxes that fall most heavily on the wealthy. Congress rejected that idea in 1950 when it abolished the authority for direct contributions from the Treasury.

Tax more income? To avoid a raise in the payroll tax rates themselves, there is a move to apply

(Continued on next page)

PENSION . . .

(Continued from page 54)

the tax to higher levels of income—to, say $4,800 of pay instead of $4,200. That way, benefit increases would be paid for entirely by larger tax payments from workers earning more than $4,200.

The trouble is that a far bigger rise than that would be required in the payroll-tax base to pay for much of a pension rise.

To get some idea of the problem Congress faces, take what is perhaps the best-known bill of the more than 100 now introduced to liberalize pensions. It is the bill of Rep. Aime J. Forand (Dem.) of Rhode Island, a member of the House Ways and Means Committee, which writes Social Security legislation. Mr. Forand's bill has the backing of organized labor—and was, in fact, written with labor's help.

As a result of pension increases in this plan, retired workers now drawing the top pension of $108.50 a month would get $118.80. The maximum for workers retiring some years from now would be $151.80—or, for a couple, $227.70, against $162.80 today. In addition, people drawing pensions and survivor benefits would get free hospital and surgical care.

What would be the cost in terms of taxes? First, the payroll tax would be applied to the first $6,000 of earnings, instead of today's $4,200. But even this sharp rise would not avoid an increase in the planned tax rate itself. Under the Forand plan, the rising tax rates now set for future years would be further increased by 1 percentage point—or three-fourths of a point for self-employed persons.

In dollars, the maximum tax that a worker and his employer would together pay in later years would rise from $357 a year under present law to a high of $570. For a self-employed person, the maximum would go from $267.75 planned under present law to a top of $427.50 under the Forand plan.

Outlook on changes. Congress, of course, could go ahead with a pension increase and wait until 1959, after the 1958 elections, to face up to the problem of paying the bills. Leaders of both parties in Congress are expected to oppose any such move. They point out that, if a payroll-tax increase linked directly with higher pensions cannot pass Congress, then a tax increase not linked to higher pensions would never be approved.

If the leaders' position prevails, then Congress will either observe its election-year tradition with a boost in both pensions and payroll taxes, or else break with its 10-year tradition and leave the Social Security program alone. Either way, it would mean that the system of retirement pay and survivor benefits will not be threatened by any action in 1958.

Dr. Parkin Recommends Study of Future of Medical Education

CHICAGO—The observation that a serious study of the future of medical education, beginning with pre-medical and extending through graduate school, must be taken in the near future was made recently by Dr. Robert C. Parkin of Madison.

Dr. Parkin, assistant to the dean of the University of Wisconsin Medical School, made the proposal following attendance at the 54th annual Congress on Medical Education and Licensure held here in February.

The study, he said, should be a cooperative effort with at least the A. M. A. and the Association of American Medical Colleges taking part. It should result in a shortened course leading to the degree of Doctor of Medicine, and a restudying of the requirements of the various specialty boards with regard to the length of their residency requirements, Dr. Parkin added.

The congress centered its attention on the future focus of medical education. It was brought out that the nation is showing a trend toward industrialization and away from agriculture; that we face the problem of an aging population, and greater competition for securing young people to enter the medical profession.

In a report, Dr. Parkin said it was obvious that medical education for the future would probably have to be telescoped so that present courses in pre-medicine and medicine overlap to save time.

Another session concerned itself with graduate and postgraduate medical education, the disappearance of the "charity" patient in the area of prepaid health insurance and also the situation wherein hospitals which support residency and intern training programs will have to seek the use of insurance supported private cases to give the graded responsibility desired.

The congress brought out some criticism regarding the establishment and approval of residencies in private hospitals. The question was raised as to the amount of responsibility to be given residents who are dealing solely with private patients of various staff members.

It was projected that in the future most residency training should be carried on in the larger university hospitals type of atmosphere beyond the period of the internship.

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MILWAUKEE WISCONSIN

STATE SCHOOL HEALTH EXAMINATION FORM HIGHLY REGARDED

Approved by SMS Division on School Health

MADISON — A grade school principal in Western Wisconsin described the special school health examination record form used in this state as the best she has seen anywhere.

"We are really happy to have such a form because it gives our work toward continuous health checkup, direction and concrete evidence of follow through on the part of the parent," she said.

The principal and other teachers said the form had several "bugs," which could be corrected without difficulty. For instance, the words "Salk Vaccine" should be added to the grouping "Special immunizations."

MANY VALUES

They said the health examination record (the front page of the form) is of value to the teacher. Quite often, however, the doctor retains this as his technical health examination data is recorded on the reverse side of the page. Thus, it is lost to school cumulative records. It often is used in place of a health guidance record in Schools.

"The biggest problem being encountered now, however, is to get 'all' doctors to give a 'complete' physical examination," the principal said.

"Last year a serious case of rheumatic fever was diagnosed and a case of hepatitis was caught in its early stages. If one case is caught each year, where help can be given in time, I feel the examination is well worth the effort and expense."

The teachers suggested putting the health examination data which the physician wishes to retain on pages three and four. Then the first half of the report, pages one and two, could be marked "this half to be sent to school."

The form has been approved by the State Medical Society's Division on School Health, the State Board of Health and the State Department of Public Instruction. Copies may be obtained from the Eau Claire Book and Stationery company in Eau Claire.

(Continued on page 60)

HEALTH EXAMINATION

Fill in each space; use space at bottom for remarks. This half to be retained in physician's office.

General appearance _____
General nutrition _____
Posture _____
Height and weight _____
Skin _____
Scalp _____
Interdigital _____
Eyes and lids _____
Vision without glasses _____R _____L
Vision with glasses _____R _____L
Other _____
Ears _____
General condition _____R _____L
Discharge _____R _____L
Hearing _____R _____L
Naso pharynx _____
Tonsils _____
Nasal obstruction _____
Mouth _____
Teeth _____
Soft Tissues _____
Thyroid _____
Lymph glands _____
Cervical _____
Other _____
Breasts _____
Lungs _____

Heart _____
Murmurs _____
Enlargement _____
Blood pressure _____
Pulse rate _____
Abdomen _____
General _____
Scars _____
Hernia _____
Genitalia _____
Undescended testicle _____
Atrophic testicle _____
Abnormalities _____
Bones and muscles _____
Chest _____
Spine _____
Upper extremities _____
Lower extremities _____
Nervous system _____
Reflexes _____
Emotional Problems _____

REMARKS:

SPECIAL TESTS AS INDICATED

X-ray _____
Urine _____
Albumin _____
Specific gravity _____
Sugar _____
Microscopic _____
Blood _____
Blood count _____
Hemoglobin _____

THIS IS THE SECOND page of the Health Examination Record form. It is one of two pages retained in the physician's office upon completion of the examination. The other page lists personal history, family history, record of illness, contact with tuberculosis, specific immunization, record of serious injuries and operation, menstruation, and chronic ailments.

PBS
PROFESSIONAL BUSINESS SERVICE
221 State Bank Building
La Crosse, Wisconsin
Business Consultants to the Medical Profession.
Inquiries Invited

—(Laurence Weksler Photo)

FOND DU LAC—Dr. H. E. Kasten, Beloit, president of the State Medical Society, was an honored guest, and presented trophies to the winners at the second annual Wisconsin Doctors' Bowling tournament here in February. In the picture above, he is presenting the award to Mrs. J. W. Boren Jr., Marinette, new auxiliary champion. She bowled a three-game aggregate of 434, a new high for the ladies' singles competition. Dr. John B. Baldi, Milwaukee, (front row left) won the men's grand championship with a 593 total, on games of 175, 196 and 222. Dr. C. M. Carney, Beloit, originator of the tourney 18 months ago, is shown in the back row (left) and his doubles partner, Dr. Erv Rechlitz, Beloit, second from right. They combined to hit 1106, topping the two-man teams. Dr. Alton J. Schmitt, Sheboygan, at right in rear row, took home the Class B (average under 150) singles with his 522 total, which come on games of 163, 163 and 196.

The Fond du Lac County Medical Society and its auxiliary were hosts to the bowlers who came from all sections of the state. More than 55 registered, more than doubling the 1957 entry. Dr. H. J. Kief, Fond du Lac, was local chairman of arrangements.

Other winners included:

Class A men's singles—Dr. M. C. Haines, Oshkosh; Dr. Leslie A. Osborn, Madison; Dr. K. G. Pinegar, Marinette; Dr. Selmer M. Feld, Milwaukee; Dr. Antoine Barrette, Peshtigo, and Dr. George F. Schweitzer, Milwaukee.

Class B men's singles—Dr. W. J. Mauermann, Beloit; Dr. George E. Collentine Jr., Milwaukee; Dr. Earl F. Winter, Oshkosh; Dr. Joseph S. Devitt, Milwaukee; Dr. E. M. Randall, Boscobel, and Dr. E. L. Bernhart, Milwaukee.

Men's Doubles—Drs. Baldi and Feld; Drs. Charles B. Koch, New Lisbon and Robert L. Smith, Marshfield; Drs. Kief and L. J. Keenan, Fond du Lac; Drs. M. F. Ries, Brownsville and Edward W. Vetter, Fond du Lac, and Drs. A. C. Edwards, Baraboo and Glenn R. Stauff, Green Bay.

High three-game series was rolled by Dr. Carney, who cracked out a 601 on games of 163, 215 and 223. Dr. Haines' 233 was the tournament's high single game.

The tournament was concluded with a party and dinner at the Fond du Lac Elk's Club. Entries asked that the 1959 meet be held at Wisconsin Rapids, and that a mixed doubles' event be added to the tournament program. If four or more communities can get together five-man teams, this event also will be included.

A SUCCESS??

How high will the social security tax go? No one knows. But in South America some countries are paying tax rates as high as 25 per cent of payroll. In France, the tax rate is 35 per cent of much of their payroll and is one of the principle reasons for the failure of the French economy to make a postwar comeback.

OK New Hospital At Friendship

WASHINGTON — The Department of Health, Education and Welfare reported recently it had approved a 20-bed hospital at Friendship, Wis., to cost $200,000, with Hill–Burton grants supplying $80,000. The hospital will be known as the Adams County Memorial Hospital.

Dane Society Honors Reporter

MADISON — The Dane County Medical Society award for the outstanding local medical story of 1957 went to John Newhouse, Wisconsin State Journal reporter, recently.

Newhouse received a plaque for his story on the discovery of penicillinase by Dr. Robert J. Becker of Madison. The discovery has been hailed as an "outstanding medical break-through."

Dr. T. J. Nereim, Madison, president of the society, said Newhouse "does a tremendous job in interpreting medicine for the public . . . his story was tactfully and gracefully done."

Penicillinase is used to counteract any ill effects which may result from the use of penicillin.

MEDICAL CLASSES REPORT INCREASE

CHICAGO—Here are some informative, interesting items from the A. M. A. relating to medical education in the United States:

There were 7,791 freshmen medical students enrolled in the nation's 82 medical schools in 1956–1957, compared with 7,686 registered in 1955–1956.

The number of graduates last June, however, declined from 6,845 to 6,796 in the same one-year period.

There were 28,852 students enrolled in the medical schools, compared with 28,639 a year earlier.

EXPENDITURES RISE

More than 62,000 others were taking courses in allied medical fields last year. The schools also assisted in the education of interns, residents, and practicing physicians doing postgraduate study, including 6,741 foreign physicians.

There were 1,646 women enrolled in medical schools last year, and 330 were graduated last June.

The medical schools spent more than $200,000,000 in 1956–1957.

Nineteen schools began projects estimated to cost $32,200,000 while 20 others completed building projects representing an investment of $67,500,000.

During 1956–1957, the schools of medicine at the University of Missouri and the University of Mississippi graduated their first classes.

A.M.E.F. REPORTS CONTRIBUTIONS, SCOPE OF EFFORT

Medical Interest, Concern Growing, Officers Say

CHICAGO—The American Medical Education Foundation received contributions totaling $65,212 from 782 Wisconsin physicians and medical organizations in 1956.

Total contributions from all sources were $3,320,152 from 84,657 contributors, including $113,467 from auxiliary organizations. The total represented a 40 per cent increase over 1955.

"This is positive proof of the interest and concern that the medical profession is exhibiting in the efforts of the foundation," Dr. Louis H. Bauer, New York City, A. M. E. F. president, said.

"Other sources of support certainly will be stimulated to help the schools remain free from federal subsidy and control."

Last year, foundation grants of $12,351 went to the Marquette University School of Medicine, Milwaukee, and $12,081 to the University of Wisconsin Medical School in Madison.

Last February, the foundation made its first separate grants to the nation's 83 medical schools. Before that, it had given its income to the National Fund for Medical Education, an organization chartered by Congress to obtain support for medical schools from industry.

TO RAISE FUNDS . . .

Sponsored and supported by the American Medical Association, the foundation was created in 1951 to help meet the rising cost of medical education, and to help forestall schools turning to the federal government for support. Its purpose was to raise funds from the medical profession for medical schools, thus setting an example to other income sources.

Through committees, set up by state and county medical societies, as well as women's auxiliaries, more than $6,000,000 has been contributed to the schools through the foundation since 1951.

In six states, Arizona, California, Idaho, Illinois, Nevada and Utah, members of the state societies contribute an amount stipulated in their dues structure.

amef

The foundation said no other form of higher education is as expensive as medical education. There are longer periods of training, expensive equipment, higher ratio of teachers to students, and new and complicated teaching techniques. In many cases, the medical schools consume 30 to 40 per cent of the budget of the university, yet enroll less than 10 per cent of the total student body.

Only 20 per cent of the costs are met by student tuition. The remaining 80 per cent comes from the nation's physicians, from the A. M. E. F., from industry and endowment programs.

The country's medical schools now:

Train 11,000 graduate doctors, interns, residents etc., and give refresher courses to 17,000 physicians.

Teach 29,000 undergraduate medical students, graduating more than 6,800 annually.

Instruct 16,000 dental, pharmaceutical and nursing students, plus 8,000 non-medical students.

Furnish leadership and counsel to health agencies.

Provide 2,000,000 people with free medical care (valued at $100,000,000).

Serve 47,000 family doctors, hospital staff members and others, through short courses.

Conduct research projects costing more than $50,000,000.

How is the A. M. E. F. money used?

One dean said it means the difference in his school of being able to retain a number of young instructors where there was no provision in the budget for the comparatively small raise required. Another dean replaced worn-out slide projector equipment essential to teaching of histology, bacteriology and other lecture courses.

Another dean spoke of numerous emergencies that come up with teachers, facilities and laboratory equipment in which A. M. E. F. unrestricted grants were used to solve problems otherwise damaging to teaching programs.

Most of the money goes for building programs, for scholarship and student aid, library, and teacher salaries.

Dr. Gunnar Gundersen, La Crosse, Wis., president-elect of the A. M. A., is a member of the foundation's board of directors.

On the A. M. E. F. honor roll to receive an award of merit is the A. Gundersen Medical Foundation of La Crosse. The award is presented each year in recognition of particularly generous gifts to the foundation.

On the S. M. S. Calendar

APRIL

16—Wisconsin Commission for the Improvement of Patient Care, Milwaukee.

24–25—Wisconsin Anti-Tuberculosis Association, Milwaukee.

28–30—Wisconsin Association for Public Health, in conjunction with Middle States Public Health Association, Milwaukee.

MAY

6–7–8—ANNUAL MEETING, STATE MEDICAL SOCIETY, MILWAUKEE!

26–June 14 — World Health Organization Assembly Meeting, Minneapolis.

SOMETHING FOR NOTHING?

"A dangerous thing about Social Security in the United States," said Ray D. Murphy, president of Equitable Society, "is that the American people have not yet come to realize that more can be given only by taking more. The nation simply does not get something for nothing in Social Security."

Chiropractor Seeks Return of Devices Seized by Government

WAUSAU—A motion, demanding the return of five devices and some publications seized from a Cumberland chiropractor last month, was entered in federal court here recently.

Counsel for I. N. Toftness, operator of the Toftness Chiropractic Clinic in the Barron County community, also asked that the machines and leaflets be suppressed as evidence against Toftness.

Judge Patrick T. Stone continued the case. Two of the devices, called Neurolinometers, were in the possession of U. S. Atty. George Rapp. They were to be tested at the University of Wisconsin in Madison.

Toftness, who designed the machines, claimed that the devices could locate nerve "interferences" in the spinal column, indicating what direction hand pressure should be applied in relieving the interference.

The government maintains the devices are worthless and were misbranded while held for sale after shipment in interstate commerce. They were sent from the Electronics Instrument Inc., Tiffin, O., to Toftness.

Frank L. Lampson, 88, Toftness' attorney, told the court he is also a patient of the chiropractor. He said that he had become dizzy recently and after two treatments, using the machine for analysis, got relief.

Lampson, of Cumberland, said that although Toftness designed the machines, he did not know how they worked—but only that they did work.

Four young chiropractors were present when a federal food and drugs agent visited the clinic last August. They were being trained in use of the machines. After three weeks training at $100 per week tuition, Toftness sold the machines for $195 each, federal officials said.

Among the literature seized was one book entitled "In Sickness and in Health," written by Larry Berlanger, editor of the Cumberland weekly newspaper, and also 26 pamphlets entitled, "The Toftness System of Spinal Correction."

Speakers Ask Stress on Food

MADISON—Dr. Conrad A. Elvehjem, dean of the graduate school and newly-named president of the University of Wisconsin, told a "Food Comes First" breakfast here recently that there is no such thing as a health food.

"Health depends on many factors and much remains to be learned about the other factors, as well as food," Dr. Elvehjem said. "Yet food is important in preventive medicine. The needs of each individual with regard to vitamins and minerals must be carefully prescribed."

The speaker listed several dangers:

Over-consumption of some foods because we like them; concentration on a few foods or vitamins because of food faddist promotion, and improper selection of foods because of price.

The week, proclaimed by President Eisenhower and Gov. Thomson, ran from Feb. 23 to March 1. It was dedicated to making Americans aware of what constituted proper, nutritional foods; to focusing attention on the evils of food faddists, and to a restatement of the facts of food and its place in human lives.

Atty. Gen. Stewart A. Honeck, speaking for Gov. Thomson, who was in Washington, said Wisconsin "is the supermarket of America." He added:

"With our population increasing and the chance of world markets through the St. Lawrence Seaway, expanding markets should eventually take care of farm surpluses, including Wisconsin dairy and farm surpluses.

"The cooperation of farmers, the University of Wisconsin and our state government has led to quantity and quality of dairy production and other foods in the state."

DENTISTS LEARN EMERGENCY CARE IN C–D PROJECT

MADISON—Nine Madison area physicians are participating in a civil defense course for dentists, arranged by the Madison Office of Civil Defense.

The course opened in January with an enrollment of 30 dentists. Stressed was this point: in no way will the dentists interfere with the medical profession during an emergency. Rather, their role will be that of supplemental aid to the doctors, thereby releasing them for more critical cases.

On the teaching staff for the 30 hours of instruction are Drs. R. F. Schoenbeck, Stoughton; and Frank D. Bernard, George H. Vogt, B. J. Longley, D. L. Williams, C. K. Kincaid, Gordon Davenport Jr., Laurence T. Giles and John H. Juhl of Madison.

Backed by the Dane County Medical Society, the program calls for instruction in caring for burns, radiation problems, management of shock, facial and jaw injuries, environmental control, medical records, organization and function of medical teams, wounds and fractures.

Three Stations Join March of Medicine

MADISON—The March of Medicine network continues to expand.

The State Medical Society's quarter-hour program, now in its 13th year, added three stations in recent weeks, WPDR, Portage, WTRW, Two Rivers, WTKM, Hartford. There are now 47 stations in the state network.

The program features Dr. Robert C. Parkin, assistant to the dean of the University of Wisconsin Medical School, and Karl Schmidt, a lay reporter.

The new stations were added with the sanction of local county medical societies.

SOCIAL SECURITY SAYS: "There is no provision in the law which permits a refund of social security taxes paid if you do not have enough work under the law to get social security payments."

In Other Words: Your uncollectable "contribution" goes to charity, and not "insurance."

SCHOOL HEALTH . . .

(Continued from page 56)

This spring the Wisconsin Congress of Parents and Teachers is conducting its annual pre-school roundup program, stressing health examinations and use of the accepted form.

Health examinations of well children differ from "special medical examinations" in that they are general examinations, with definite educational objectives. They are not directed to any particular condition or area of the body. The specific purposes are:

1. To determine the growth and development of individual pupils so as to provide each teacher with information on this topic.
2. To find pupils in need of medical and dental services and to identify pupils who have health problems requiring attention other than medical and dental treatment.
3. To find pupils with non-remedial defects who may be in need of special education programs, enrollment in a sight-saving class, adapted physical education, or other special services.
4. To find evidence of faulty health habits and to suggest the correction of these habits, and also
5. To provide an educational experience for the child.

If given in school, the health examination is not intended to be final. It is intended as a screening process. When given in the doctor's office, immediate follow-through with needed diagnostic and remedial measures is possible.

What are the contents of the approved health examination?

1. Examine the nose, mouth and throat for inflammatory discharges, obstructive growths or abnormalities.
2. Palpate for lymph node and thyroid enlargement.
3. Note deformities of the chest, spine and extremities.
4. Using a stethoscope placed directly on the skin, determine the condition of the heart and lungs. Tests should be made before exercise; then have the pupil exercise by making "step-ups" or several "push-ups" from the floor; then listen immediately for murmurs and to determine heart rate. Listen over each lobe for rales and after two minutes record the recovery pulse rate.
5. Test males for inguinal and umbilical hernia.
6. Note habitual posture and advise pupil at once if there are uneven shoulders, protruding abdomen, abnormal curvatures, or relaxed foot arches.
7. Examine toes for fungus growth.
8. Examine scalp and skin.
9. Take blood pressure and collect samples of hemoglobin determination and urinalysis.
10. Examine mouth and teeth according to plan approved by local dental society.

"School Health Examinations," a guide for physicians and school authorities, was published several years ago by the State Medical Society's Division on School Health. Copies may be obtained by writing Box 1109, Madison 1.

The guide details the organization of the health examination program, the scope, the maintenance of records, follow-through and the health of school personnel. Also, the publication outlines readiness for the school program, sample forms and reporting procedure.

NAME MACLACHLAN TO S.M.S. STAFF

MADISON—The State Medical Society recently announced the appointment of James H. MacLachlan as an executive assistant in public information.

A native of Park Falls, MacLachlan has been employed at Madison Central high school and the Straus Printing company in Madison. He is now teaching advertising at the Madison Vocational School.

MacLachlan is a graduate of the University of Wisconsin.

Urge Chest X-Ray Hospital Programs

MILWAUKEE—One of the most effective means of finding lung cancer and heart abnormalities, as well as tuberculosis, is by routine admission chest x-ray programs in general hospitals.

That was the conclusion drawn by speakers at a recent conference on radiation programs, arranged by the Wisconsin Anti-Tuberculosis Association, for hospital administrators and trustees, physicians, public health and health agency representatives.

They also agreed that:

The dangers of radiation exposure are slight and are far outweighed by the advantages and results to be gained. However, excessive exposure should be avoided wherever possible, and ample safeguards employed.

The program should be used as a case-finding tool, to locate conditions in early asymptomatic stages, and for medical history.

Dr. T. L. Badger, of the Harvard Medical School, president of the American Trudeau Society, said x-ray upon admission to a hospital may lead to discovery of tuberculosis, especially older persons who are not tested in schools regularly as are younger groups.

DOCTOR!

Have you made arrangements to attend the 117th Annual Meeting of the State Medical Society in Milwaukee May 6–8?

Colleges Proud of Doctor-Graduates

MILWAUKEE—Jamie, Milwaukee Sentinel columnist, recently asked the public relations director of Milwaukee–Downer College how graduates of the school had distinguished themselves in medicine, and in other fields.

This was her answer:

DOCTORS: In the field of medicine, a number of MDC graduates are practicing physicians. Among them are Dr. Beatrice O. Jones, and Dr. Elizabeth A. Steffen of Racine. Dr. Elizabeth R. Baldwin has been named to the Wisconsin State Board of Health by Gov. Thomson. Dr. Baldwin is mother of four children. Her father, Edwin Reddeman, is president of the American State Bank, Milwaukee. Dr. Baldwin and her husband are practicing physicians in Marshfield.

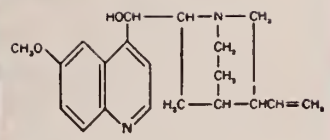
Progress in SYNTHETIC CHEMISTRY EQUALS Progress in CHEMOTHERAPEUTICS

"It has a high degree of clinical safety. . . It is considered to be the preferred antimalarial drug for treatment of disorders of connective tissue, because of the low incidence of gastrointestinal distress as compared to that with chloroquine phosphate."[1]

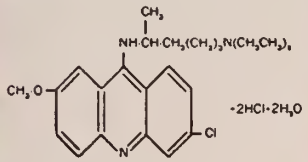
". . . Plaquenil is decidedly less toxic and better tolerated by the average patient, even in high dosage, than is chloroquine."[2]

". . . the least toxic of its class . . ."[3]

QUININE



ATABRINE® HYDROCHLORIDE



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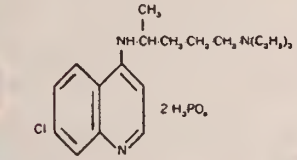

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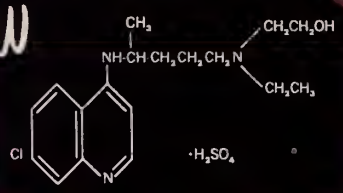

Plaquenil® SULFATE

Remarkably effective in **RHEUMATOID ARTHRITIS**

SIDE EFFECTS MARKEDLY REDUCED

DOSE: **Initial** — 400 to 600 mg. (2 or 3 tablets) Plaquenil sulfate daily.
Maintenance — 200 to 400 mg. (1 or 2 tablets) daily.

SUPPLIED: Tablets of 200 mg., bottles of 100.

Write for Booklet

Winthrop LABORATORIES NEW YORK 18, N. Y.

RENCES:
herbel, A.L., Schuchter, S.L., and Harrison, J.W.: *Cleveland Clin. Quart.* 24:98, Apr., 1957.
ditorial: *Bull A. Mil. Dermatologists*, The Shock Section 5:25, Nov., 1956.

Atabrine (brand of quinacrine), Aralen (brand of chloroquine)

News Items and Personals

Cochrane Doctor Honored at Dinner

A testimonial dinner honoring *Dr. E. A. Meili* of Cochrane was held in Minnesota City early in September. The sponsoring organization, the Cochrane Booster Club, planned the event in order that the people of Cochrane and surrounding communities could have an opportunity to show their appreciation for the 25 years of service that the doctor had given to that area.

Doctor Meili is a 1931 graduate of the University of Wisconsin Medical School and served internships at the Kansas City General Hospital; Derge Clinic, Eau Claire; and hospitals in Milwaukee and Chicago.

Hospital Anniversary Observed

In October, *Dr.* and Mrs. *R. L. MacCornack, Sr.*, Whitehall, entertained at a banquet to celebrate the 40th anniversay of the Whitehall Community Hospital. Members of the board of trustees and guests were present. Doctor MacCornack, president of the board of trustees, gave a brief history of the hospital and stated that he and his staff are dedicated to the continued progress of the hospital and to extending its services. First among the plans for extending such services is the addition of a radiologist to the staff.

Dr. Simenstad Joins Clinic Staff

Dr. John O. Simenstad recently joined the Osceola Clinic, Osceola. He was discharged from the army at Camp Wolter, Mineral Wells, Texas, after two years of service.

New Clinic Opens in Menasha

A 60-room medical clinic was opened on October 21 in Menasha. The physicians practicing there are Wallace Bailey, *George Hildebrand, William Hildebrand, George Pratt, Jr., George Schwei, John Conway,* and *Ernest Strakosch.* There is also an office for a dentist, Dr. R. A. Juneau.

The clinic is equipped with air-conditioning, its own pharmacy, a private entrance for wheel chair patients, a physiotherapy room, and a complete laboratory. There are large waiting rooms on each floor with a view of the Fox River, and a parking lot which will accommodate 30 cars.

Dr. Solberg Moves to Viola

Dr. Marvin E. Solberg, a former Milwaukee physician, has opened an office for general medicine and surgery in Viola. The doctor is a graduate of Marquette University School of Medicine. He served in the Army Medical Corps during World War II and has practiced in Milwaukee since his discharge.

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when anxiety and tension "erupts" in the G. I. tract...

IN DUODENAL ULCER

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Meprobamate with PATHILON® Lederle

Combines Meprobamate (*400 mg.*) the most widely prescribed tranquilizer . . . helps control the "emotional overlay" of duodenal ulcer — without fear of barbiturate loginess, hangover or habituation . . . *with* PATHILON (*25 mg.*) the anticholinergic noted for its extremely low toxicity and high effectiveness in the treatment of many G.I. disorders.

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Dr. McCarthy Leaves Hillsboro

Dr. Mor J. McCarthy, a Hillsboro physician since 1955, recently terminated his practice there. He will return to Washington, D. C., his home city to establish a practice. The doctor and his family will be living in Chevy Chase, Maryland.

Physicians Participate in Heart Association Conferences

The Southeast District Heart Committee of the Wisconsin Heart Association sponsored "The Cardiac Can Work" conferences held in Racine during October and in Kenosha during January. Physicians who served on the panel in Racine were *Drs. C. R. Newman*, Racine; *Elston L. Belknap*, Milwaukee; and *Robert S. Wright*, Racine. Those participating in the Kenosha panel were Drs. Belknap; *J. T. Duncan, Jr.*, Kenosha; and *W. A. Mudge, Jr.*, Kenosha.

Rotary Club Hears Dr. Rudy

That there is a growing awareness of the fact that a child who has a physical handicap also is handicapped with respect to emotional growth was pointed out by *Dr. Warren Rudy*, a Wausau pediatrician, when he addressed the November 4 meeting of the Wausau Rotary Club. Doctor Rudy urged the Rotarians to put the emphasis on "ability, not disability" when talking to a handicapped child. The handicapped boy, for example, should not be told that it is too bad that he cannot play football, but rather that it is a fine thing that he is able to participate in a music program or other activities.

Dr. Seward Addresses Staff Meeting

A paper on "Electrolyte Balance" was read by *Dr. L. J. Seward*, Berlin, at the November scientific meeting of the Berlin Memorial Hospital medical staff. The staff meets on the second Tuesday of each month to hear a paper on some scientific subject, and on the fourth Tuesday it holds its business meeting.

Spring Green Has New Physician

Dr. Otto Rosemeyer, a native of Germany, opened an office in Spring Green during November. The doctor began the study of medicine in 1936 at Düsseldorf and Hamburg, Germany. In 1942 he took his state board examination and then practiced a year in internal medicine, three years in gynecology, and eight years in surgery, receiving his special license for surgery in 1950. In 1955 he moved to Canada, where he learned the English language. Doctor Rosemeyer received his license to practice in the United States last July.

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salicylate benefits with minimal salicylate drawbacks

Rapid and prolonged relief—with less intolerance. The analgesic and specific anti-inflammatory action of BUFFERIN helps reduce pain and joint edema—comfortably. BUFFERIN caused no gastric distress in 70 per cent of hospitalized arthritics with proved intolerance to aspirin. (Arthritics are at least 3 to 10 times as intolerant to straight aspirin as the general population.[1])

No sodium accumulation. Because BUFFERIN is sodium free, massive dosage for prolonged periods will not cause sodium accumulation or edema, even in cardiovascular cases.

Each *sodium-free* BUFFERIN tablet contains acetylsalicylic acid, 5 grains, and the antacids magnesium carbonate and aluminum glycinate.

Reference: 1. J.A.M.A. 158:386 (June 4) 1955.

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actually **lowers*** gastric secretion

*Tests in a series of 25 patients show that there is "a definite and distinct lowering [of both volume of secretions and of free hydrochloric acid] in the majority of patients. . . . No patients had shown any increase in gastric secretions following administration of the drug."[1]

Now you have 4 advantages when you calm ulcer patients with ATARAX:

1. ATARAX suppresses gastric secretions; others commonly increase acidity.
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3. It is effective in 9 of every 10 tense and anxious patients.
4. Five dosage forms give you maximum flexibility.

supplied: 10, 25 and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

references: 1. Strub, I. H.: Personal communication. 2. Ayd, F. J., Jr.: presented at Ohio Assembly of General Practice, 7th Annual Scientific Assembly, Columbus, September 18-19, 1957.

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American College of Physicians Fellows

An announcement was made recently that the following Wisconsin physicians had been named Fellows of the College: *Drs. J. H. Wishart*, Eau Claire; *J. R. Talbot*, Madison; and *R. W. Boyle* and *R. E. Yunck*, both of Milwaukee.

Green Bay Has New Pediatrician

On October 1, *Dr. Daniel W. Shea* started his pediatric practice in the same office with *Dr. Richard L. Myers* of Green Bay. Doctor Shea received his master of science degree in pediatrics from the University of Minnesota in August, 1957. Prior to that he served a three-year pediatric fellowship at the Mayo Foundation, Rochester, Minnesota. The doctor is a graduate of the St. Louis School of Medicine, St. Louis, Missouri.

Dr. Murphy Joins Hospital, Clinic Staffs in La Crosse

Staff officials of the Gundersen Clinic and the La Crosse Lutheran Hospital have announced that Dr. George B. Murphy, Jr. has joined their surgical staff. Doctor Murphy is a 1951 graduate of Harvard Medical School and served his internship and residency at Massachusetts General Hospital. From 1952 to 1954 he was on active duty as a medical officer with the United States Navy.

Dr. Shaiken Elected to National Post

Dr. Joseph Shaiken, Milwaukee, was elected first vice-president of the American College of Gastroenterology at its annual convention held last fall in Boston, Massachusetts.

Heart Association Presents Lectures

The Malcolm F. Rogers lectures sponsored by the Wisconsin Heart Association in cooperation with Marquette University and the University of Wisconsin were held in Madison and Milwaukee on October 22–23. Two heart specialists, Dr. Charles E. Kossmann, associate professor of medicine at New York University College of Medicine, and Dr. Samuel A. Levine, clinical professor of medicine at Harvard Medical School, Boston, were the guest lecturers.

These lectures are arranged each year, with two eminent physicians as guests by the Wisconsin Heart Association as part of its medical education program.

when anxiety and tension "erupts" in the G. I. tract...

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Postgraduate Course Held at Monroe Clinic

During October the Monroe Clinic was closed for general business for one day while 50 area physicians took a six-credit postgraduate course, approved by the Wisconsin Academy of General Practice. *Dr. Edward Zupanc* was conference chairman, assisted by *Dr. Eugene E. Eckstam* and *Dr. Robert G. Zach.*

The morning session included talks on "Surgical Management of Common Chest Lesions," by Doctor Eckstam; "Abdominal Pain in Children," by *Dr. Frank C. Stiles;* and "Practical Aspects in the Management of the Ambulatory Diabetic," by *Dr. Leslie G. Kindschi.* In the afternoon there were talks on "The Diagnosis of Brain Tumors," by Dr. A. Y. Gerol; "Superficial Mycotic Infections," by *Dr. Edward H. Ferguson;* and "Causes of Dysphagia," by Doctor Zach.

The late *Dr. John A. Schindler* discussed his last book, *Women's Guide for Better Living,* at the social hour and dinner which was held at the Country Club after the lectures.

Two New Doctors at Stoughton

In the early part of November two new physicians opened offices in Stoughton. Dr. Francis M. Schammel graduated from the University of Illinois School of Medicine in 1954 and served his internship at St. Luke's Hospital, Duluth, Minnesota, from 1954 to 1955. He was a captain in the medical corps from 1955 to 1957.

Dr. Orin A. Hermundstad received his medical degree from the Baylor University College of Medicine, Houston, Texas. He interned at St. Luke's Hospital at the same time that Doctor Schammel was there, and also served as a captain in the medical corps from 1955 to 1957.

"Clinic Day" at St. Joseph's Hospital

St. Joseph's Hospital, Milwaukee, sponsored its first annual "Clinic Day" during November. Among the speakers was Dr. Edward W. Gall of Cincinnati University. He conducted a seminar on liver ailments and was then questioned by a panel of Milwaukee physicians.

The clinic day, which is an extension of the hospital's education program was divided into morning and afternoon sessions. *Dr. Samuel Rosenthal,* hospital chief-of-staff, headed the morning session, and *Dr. F. D. Murphy* was in charge of the afternoon meeting.

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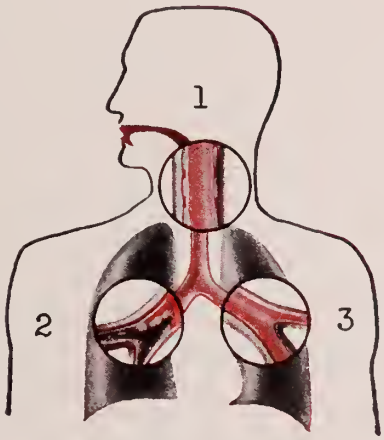
breaks up cough*



*Drawing shows how 3-pronged attack of Pyribenzamine Expectorant with Ephedrine breaks up cough by: (1) reducing histamine-induced congestion and irritation throughout the respiratory tract; (2) liquefying thick and tenacious mucus; (3) relaxing bronchioles. Pyribenzamine Expectorant with Codeine and Ephedrine also available (exempt narcotic). Pyribenzamine® citrate (tripelennamine citrate CIBA). C I B A

Munn–Koch Clinic Adds Staff Member

Dr. Edwin F. McNichols, who practiced internal medicine in Greencastle, Indiana, during the past year, has become associated with the Munn-Koch Clinic of Janesville. Following graduation from Loyola Medical School, the doctor spent one year as an intern, and one year as a resident in internal medicine at Milwaukee General Hospital. He was a resident in internal medicine at Kennedy Veterans Administraton Training Group Hospital, Memphis, Tennessee, from 1954 to 1956.

While in private practice in Greencastle, Doctor McNichol was director of student house services at De Pauw University.

Portage Hospital Names Staff Officers

Dr. R. F. Inman of Montello was re-elected chief-of-staff of the Divine Savior Hospital in Portage at the annual staff meeting held in December. The group named *Dr. Jack Saxe*, Portage, vice chief- of-staff, and *Dr. T. E. Henney*, Portage, secretary-treasurer.

Dr. Messer Joins Jackson Clinic Staff

Dr. James W. Messer, a graduate of Johns Hopkins University School of Medicine, Baltimore, has joined the staffs of the Jackson Clinic and Methodist Hospital, Madison. He will practice internal medicine and endoscopy. After serving in the Navy during World War II, Doctor Messer attended Harvard University. Following his graduation from medical school he interned at the Johns Hopkins Hospital, and then became associated with the Mayo Clinic, Rochester, Minnesota, where his special interest was diseases of the chest.

He is a member of the American Diabetes Association and an Associate Fellow of the American College of Chest Physicians.

Dr. Stovall Speaks at Health Council Meet

Some 200 women from rural Dane County attended the 12th annual meeting of the Dane County Association of Health Councils. The speaker of the day was *Dr. William D. Stovall*, Madison, director of the State Laboratory of Hygiene, who chose "How are We Meeting the Health Needs of Dane County Citizens?" as the title of his talk.

Dr. Samp Talks on Medicines

Dr. Robert J. Samp, Madison, recently addressed the Sheboygan Catholic Daughters of America. He stated that any medicines over six months old should be thrown away, and he urged his audience to check the contents of their medicine cabinets. "Avoid remedies used by other people; prescriptions have a sacred specificity. Though they are your very own, they may not cure your neighbor," he advised. Doctor Samp terminated his talk with a prescription for common sense—a good frame of mind . . . and the use of the scientific means provided by the medical profession.

Doctor Stuff Begins Practice at Bonduel

Dr. Patricia J. Stuff recently joined the medical staff of the Bonduel Clinic which was opened last fall by her husband, Dr. W. W. Grover.

A native of Polo, Ill., Doctor Stuff received her doctor of medicine degree at the Woman's Medical College at Philadelphia and took her internship at St. Luke's Hospital in Chicago. Her residency in general practice was completed at Sacred Heart Hospital, Yankton, S. D.

Doctor Stuff and Doctor Grover were brought to Bonduel through the efforts of a local committee and the State Medical Society's placement service. The village had been without a resident physician since the death of Dr. J. H. Terlinden in November, 1956.

Dr. Stewart Speaks on Mental Health

Dr. Katherine Stewart, Eau Claire, spoke to the Barron County Woman's Club recently on work of the Mental Health Association of Eau Claire, which she serves as president.

Open New Medical Building at Kenosha

A contemporary office building with nine professional suites for physicians was opened recently in Kenosha. There are also facilities for two dentists and a pharmacy.

Construction of the building accentuated easy access, one floor, and a large parking lot. More than 7,500 square feet of floor space were provided, with each suite containing three examining rooms, a large waiting room, a laboratory and a reception room.

Doctor Schroeder Plans New Office

Initial plans for a medical-dental building were announced in Sheboygan recently by Dr. Irvin L. Schroeder. Construction is expected to start late this spring on a 150 by 150 lot, purchased by Doctor Schroeder and Dr. Donald Imig, a dentist, from the First Presbyterian Church of Sheboygan.

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with lower dosage
(averages 1/3 less than
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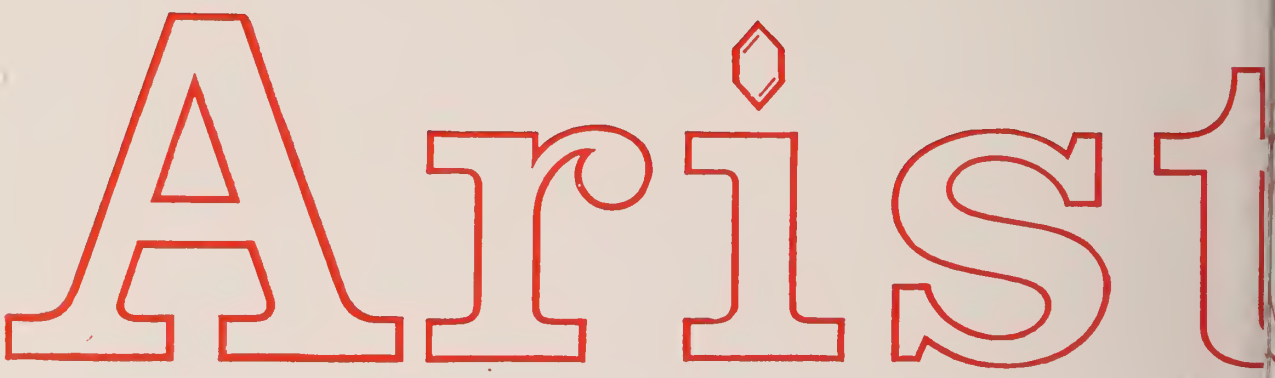
The Achievement in Rheumatoid Arthritis: Impressive therapeutic effect in most cases of a group of 89 patients[4]...6 mg. of ARISTOCORT corresponded in effect to 10 mg. of prednisone daily (in addition, gastric ulcer which developed during prednisone therapy in 2 cases disappeared during ARISTOCORT therapy).[5]



1. Rein, C. R., Fleischmajer, R., and Rosenthal, A. L.: J. A. M. A. *165*:1821, (Dec. 7) 1957.
2. Shelley, W. B., and Pillsbury, D. M.: Personal Communication.
3. Sherwood, A., and Cooke, R. A.: Personal Communication.
4. Freyberg, R. H., Berntsen, C. A., and Hellman, L.: Paper presented at International Congress on Rheumatic Diseases, Toronto, June 25, 1957.
5. Hartung, E. F.: Personal Communication.
6. Schwartz, E.: Personal Communication.
7. Sherwood, A., and Cooke, R. A.: J. Allergy 28:97, 1957.
8. Hellman, L., Zumoff, B., Kretshmer, N., and Kramer, B.: Paper presented at Nephrosis Conference, Bethesda, Md., Oct. 26, 1957.
9. Ibid.: Personal Communication.
10. Barach, A. L.: Personal Communication.
11. Segal, M. S.: Personal Communication.
12. Cooke, R. A.: Personal Communication.
13. Dubois, E. L.: Personal Communication.

The Achievement in Respiratory Allergies: "Good to excellent" results in 29 of 30 patients with chronic intractable bronchial asthma at an average daily dosage of only 7 mg.[6]... Average dosage of 6 mg. daily to control asthma and 2 to 6 mg. to control allergic rhinitis in a group of 42 patients, with an actual reduction of blood pressure in 12 of these.[7]

The Achievement in Other Conditions: Two failures, 4 partial remissions and 8 cases with complete disappearance of abnormal chemical findings lead to characterization of ARISTOCORT as possibly the most desirable steroid to date in treatment of the nephrotic syndrome.[8,9]... Prompt decrease in the cyanosis and dyspnea of pulmonary emphysema and fibrosis, with marked improvement in patients refractory to prednisone.[10,11,12]... Favorable response reported for 25 of 28 cases of disseminated lupus erythematosus.[13]

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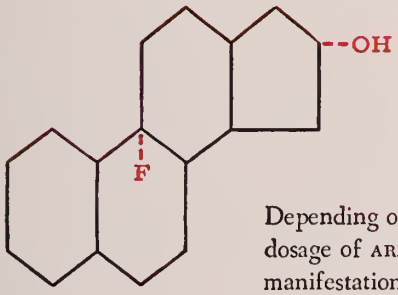

Depending on the acuteness and severity of the disease under therapy, the initial dosage of ARISTOCORT is usually from 8 to 20 mg. daily. When acute manifestations have subsided, maintenance dosage is arrived at gradually, usually by reducing the total daily dosage 2 mg. every 3 days until the smallest dosage has been reached which will suppress symptoms.

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Zinc Bacitracin	50 units
Tyrothricin	1 mg.
Neomycin sulfate (equivalent to 3.5 mg. neomycin base)	5 mg.
Benzocaine	5 mg.

MSD

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Society Records

New Members

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R. A. Higley, 8500 West North Avenue, Milwaukee.

Albert Kniaz, Milwaukee City Hospital for Mental Diseases, Milwaukee.

T. P. Borowski, 3535 West Oklahoma Avenue, Milwaukee.

M. F. Lindquist, Milwaukee County Hospital, Milwaukee.

C. J. Sherkow, 208 East Wisconsin Avenue, Milwaukee.

C. M. Shon, 3238 North Marietta, Milwaukee.

C. L. Weisenthal, V. A. Hospital, Wood.

G. F. Flynn, 807 North 115th Street, Milwaukee.

J. R. Bobo, Sr., 2009 North 10th Street, Milwaukee.

J. E. Kippenhan, 204 North Washington Avenue, Cedarburg.

Philip Wallestad, Fredonia.

Patricia J. Stuff, P. O. Box 522, Bonduel.

D. M. Ericksen, Milltown.

Michael Stoklos, 17735 West Pleasant Street, Brookfield.

G. B. Murphy, Jr., 1836 South Avenue, La Crosse.

A. J. Herlitzka, 808 Third Street, Wausau.

A. J. Molinaro, 501 Jefferson Street, Wausau.

E. A. Clayton, 730 Washington Avenue, Racine.

F. M. Schammel, 131 West Chicago Avenue, Stoughton.

O. A. Hermundstad, 200 East Main Street, Stoughton.

Jordon Frank, 925 Mound Street, Madison.

C. R. Starr, 2021 University Avenue, Madison.

D. T. Graham, 1300 University Avenue, Madison.

K. A. Forbes, Bellin Building, Green Bay.

R. H. Owen, 1307 Jewel Court, Madison.

C. R. Jackson, 1027 East Johnson Street, Madison.

J. R. Johnson, 1111 Oak Way, Madison.

Eleanor E. Giffin, 30 South Main Street, Fond du Lac.

C. A. Graf, Hartl Manor, Marshfield.

Change of Address

E. E. Bertolaet, Kenosha, to 2553 South 90th Street, West Allis.

E. G. Olmstead, Milwaukee, to 1127 Walnut Avenue, Grand Forks, North Dakota.

L. R. Pfeiffer, Strum, to Nekoosa.

F. J. Ansfield, Glidden, to 505 North Midvale Boulevard, Madison.

P. D. Nelson,** Bethesda, Maryland, to U. S. Naval Hospital, Philadelphia, Pennsylvania.

R. B. Ainslie, Madison, to 2020 East 93rd Street, Cleveland, Ohio.

E. H. Wood, Madison, to 4800 Gibson Boulevard, Southeast, Albuquerque, New Mexico.

G. T. Huckle, Madison, to 650 South Central Avenue, Marshfield.

H. W. Sargeant, Milwaukee, to Long Prairie Community Hospital, Long Prairie.

J. F. Becker, Skokie, Illinois, to 1720 East Lake Bluff Boulevard, Milwaukee.

J. F. Orlovsky,** Milwaukee, to 153 Nickolson Road, Fort Sheridan, Illinois.

E. R. Loftus, Statesan, to Winnebago State Hospital, Winnebago.

A. M. Kowalski,** Milwaukee, to 2214 Williams, Lawton, Oklahoma.

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"Furthermore, the duration of this beneficial action is prolonged sufficiently to make this method of treatment of practical clinical value."

Riseman, J. E. F., Altman, G. E., and Koretsky, S.: Nitroglycerin and Other Nitrites in the Treatment of Angina Pectoris, Circulation (Jan.) 1958.

* 'Cardilate' brand Erythrol Tetranitrate SUBLINGUAL TABLETS, 15 mg. scored

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OBITUARIES

Dr. V. C. Kremser, Amery, died suddenly on July 12 at the age of 49.

Born in 1908 in Cudahy, he attended Marquette University, where he graduated from medical school in 1934. He practiced briefly in Amherst before moving to Amery in 1935.

He was a member of the State Medical Society of Wisconsin, the Polk County Medical Society, the American Medical Association, and the Academy of General Practice.

His wife and two children survive.

Dr. Christine J. Ivanov, 43, passed away July 31.

Born in 1913 in Milwaukee, Doctor Ivanov spent most of her life there. She graduated from Marquette University School of Medicine in 1953, interned at Milwaukee Hospital, and at the time of her death was taking residency training in psychiatry at the Milwaukee County Hospital for Mental Diseases.

She was a member of the State Medical Society of Wisconsin, the Medical Society of Milwaukee County, the American Medical Association, the New York Academy of Science, and the Women's Medical Society.

Survivors are Mr. Alex Ivanov, her brother, and Mrs. Mary Collins, sister.

Dr. J. B. Ozonoff, a Milwaukee general practitioner, passed away October 23 at the age of 60.

He was born in Russia in 1896. He received a medical degree from the University of Illinois in 1925, and he also became a naturalized citizen of the United States in that year. After completing an internship in 1926 at Alexian Brothers Hospital in Chicago, he began practice in Milwaukee. Doctor Ozonoff had also served as a selective service examiner.

Society memberships included those in the State Medical Society of Wisconsin, the Medical Society of Milwaukee County, the American Medical Association, and the American Academy of General Practice.

Doctor Ozonoff is survived by his wife and three children.

Dr. John A. Hurlbut, 59, of Madison, died December 22.

He was born near Boscobel in 1898 and since completing a residency at Methodist Hospital, Madi-

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son, in 1925 had been in practice at the Jackson Clinic in Madison. His medical degree was obtained at Northwestern University Medical School in 1924.

Doctor Hurlbut was a specialist in otology, laryngology, and rhinology and a member of the American Society of Ophthalmology and Otolaryngology, the State Medical Society of Wisconsin, the Dane County Medical Society, and the American Medical Association.

Surviving are a son, Jack, Madison, and a sister, Mrs. Hazel Benbrook, Chicago.

Dr. H. J. Kuhn, Milwaukee, died November 8 at the age of 66.

Doctor Kuhn was born in 1891 in Milwaukee. He attended St. Louis University School of Medicine and following graduation in 1917, he interned at Milwaukee County Hospital. Then he began a general practice at Milwaukee with special attention given to internal medicine. For a number of years Doctor Kuhn was assistant clinical professor of medicine at Marquette University School of Medicine. In 1956 he was forced into retirement because of ill health.

He was a member of the State Medical Society of Wisconsin, the Medical Society of Milwaukee County, and the American Medical Association.

Doctor Kuhn is survived by his wife.

Dr. George H. Reddick died unexpectedly on December 5 at the age of 69. He had practiced in Wabeno for 41 years.

Born in 1888 in Winamac, Indiana, he was graduated from the Chicago College of Medicine and Surgery in 1914. He served as a surgeon in World War I and followed with employment in the U. S. Public Health Commission and at Wood VA Hospital before settling in Wabeno. For several years he was employed as railroad surgeon in Wabeno.

Doctor Reddick served during World War I in England and France. He was honored with the British Military Cross, French Croix de Guerre, and the American Purple Heart. Later he was responsible for the organization of the American Legion Post in Wabeno. He served for many years as service officer of local units of the American Legion, Veterans of Foreign Wars and Disabled American Veterans.

Doctor Reddick was a member of the active staff of the St. Vincent's Hospital of Green Bay, 85 miles from his established practice.

He was a member of the State Medical Society of Wisconsin, the Brown County Medical Society, the American Medical Association, the Industrial Surgeons of U. S. and the Railway Surgeons of U. S.

There survive a wife and two daughters.

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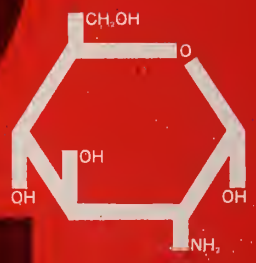

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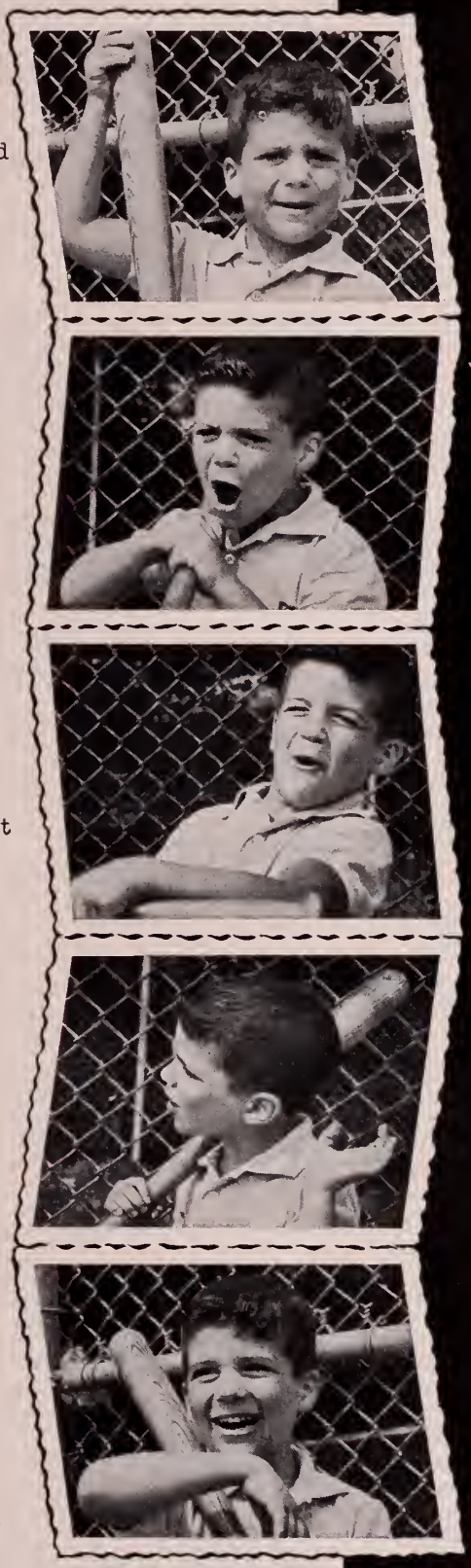

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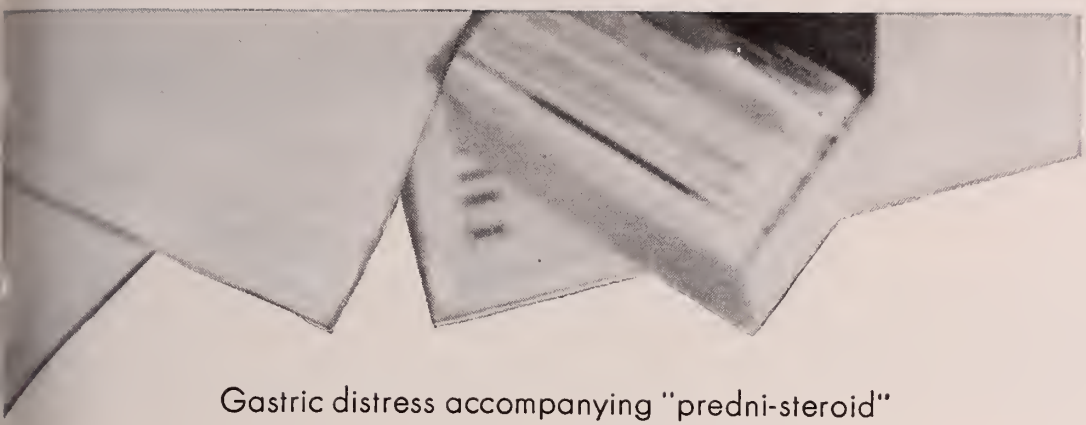

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*"It is our growing conviction that all patients receiving oral steroids should take each dose after food or with adequate buffering with aluminum or magnesium hydroxide preparations."—Sigler, J. W. and Ensign, D. C.: J. Kentucky State M. A. 54:771 (Sept.) 1956.

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1. Waldman, S., and Pelner, L.: Am. Pract. & Digest Treat. *8*:1075 (July) 1957.

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Doctor Cohen to England

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The Foundation is an international philanthropic organization which supports research.

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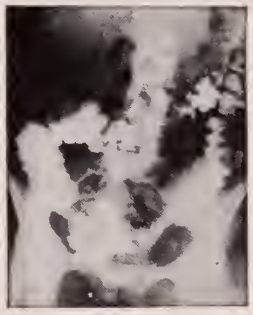

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*Morrison, L. F.: Arch. Otolaryng. 59:48-53 (Jan.) 1954.

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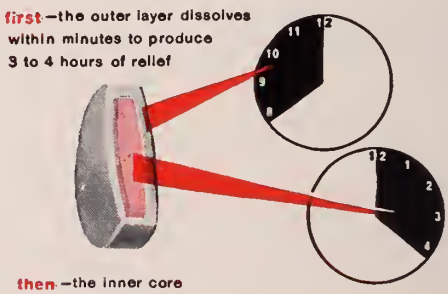

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Thirteenth District:
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L. O. Simenstad----------Osceola
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(Terms end on December 31 of year indicated)

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D. H. Witte, Milwaukee, 1958
J. C. Griffith, Milwaukee, 1959
William D. Stovall, Madison, 1959

Alternates

L. O. Simenstad, Osceola, 1958
E. L. Bernhart, Milwaukee, 1958
R. E. Galasinski, Milwaukee, 1959
A. A. Quisling, Madison, 1959

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List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland–Bayfield–Iron	H. V. Sandin 220 Seventh W. Ashland	C. A. Grand 522 W. Second Ashland	
Barron–Washburn–Sawyer–Burnett	C. J. Strang Barron	H. M. Templeton Barron	Second Tuesday 7:30 p.m.
Brown	George Nadeau 128 E. Walnut Green Bay	Frank Urban 305 E. Walnut Green Bay	Second Thursday*
Calumet	J. A. Knauf Stockbridge	K. R. Humke Chilton	
Chippewa	B. J. Haines Cadott	R. L. Hendrickson 12 Third Cornell	Second Tuesday
Clark	T. N. Thompson, Jr. Neillsville	H. M. Braswell, Jr. Owen	
Columbia–Marquette–Adams	H. A. Winkler 115 W. Chestnut Pardeeville	T. S. Westcott Pardeeville	Every Third Month 7:00 p.m.
Crawford	O. E. Satter Prairie du Chien	H. L. Shapiro Prairie du Chien	Third Wednesday
Dane	T. J. Nereim 3710 Spring Trail Madison	A. P. Schoenenberger 122 W. Washington Madison	Second Tuesday Sept. through June
Dodge	R. F. Boock 119½ Front Beaver Dam	G. G. Drescher 106½ Front Beaver Dam	Last Thursday*
Door–Kewaunee	J. G. Beck Sturgeon Bay	J. F. March 413 4th Algoma	
Douglas	R. T. Anderson 1507 Tower Superior	L. R. Rosin 2231 E. Fifth Superior	First Wednesday** Hotel Superior
Eau Claire–Dunn–Pepin	D. M. Willison 314 E. Grand Eau Claire	K. E. Walter 131 S. Barstow Eau Claire	Last Monday
Fond du Lac	John C. McCullough 20 Forest Fond du Lac	R. W. Schroeder 330 Ledgeview Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley Wabeno	D. V. Moffet Crandon	
Grant	H. L. Doeringfeld Platteville	H. W. Carey Lancaster	Last Thursday, March, June, Sept. and Nov.
Green	M. W. Stuessy Brodhead	R. G. Zach Monroe Clinic Monroe	
Green Lake–Waushara	G. G. Mueller Princeton	J. C. Koch Berlin	Last Thursday, every other month starting in Jan.
Iowa	C. L. White Mineral Point	E. J. Hohler Mineral Point	First Thursday following first Monday
Jefferson	E. E. Burzynski 113 N. Third Watertown	E. P. Schuh 706 Madison Watertown	Third Thursday*
Juneau	J. H. Vedner Mauston	J. S. Hess Mauston	Second Tuesday Hess Clinic in Mauston

* Except June, July, and August.

** Except July and August.

List of Officers and Scheduled Meetings of County Medical Societies—Continued

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Kenosha	W. C. Kleinpell 723 58th Kenosha	Mr. L. F. Jost, Ex. Sec. Box 669 Kenosha	First Thursday* Elks Club
La Crosse	F. J. Gallagher 630 S. Tenth La Crosse	J. B. Durst 1707 Main La Crosse	Third Monday
Lafayette	R. E. Hunter Argyle	N. A. McGreane 123 E. Ann Darlington	Last Tuesday
Langlade	R. W. Cromer 824½ Fifth Antigo	J. E. Garritty Antigo	First Monday
Lincoln	F. C. Lane 401 W. Main Merrill	J. D. Millenbah 121 S. Mill Merrill	
Manitowoc	J. W. Steckbauer Suite 304, Savings Bank Building Manitowoc	R. J. Banker 709 Washington Manitowoc	Last Thursday
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Milwaukee	S. A. Morton 3321 N. Maryland Milwaukee	L. R. Schweiger 324 E. Wisconsin Mr. J. O. Kelley, Ex. Sec. 756 N. Milwaukee Milwaukee	Second Thursday
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Oconto	H. A. Aageson 1113 Main Oconto	C. E. Siefert Oconto Falls	
Oneida–Vilas	T. M. Haug 1020 Kabel Rhinelander	Marvin Wright 1020 Kabel Rhinelander	Monthly
Outagamie	George A. Behnke 240 W. Wisconsin Kaukauna	George A. French 601 W. College Appleton	Third Thursday* Elks Club
Pierce–St. Croix	G. E. Bourget Hudson	P. H. Gutzler River Falls	Third Tuesday
Polk	Stella I. Burdette Balsam Lake	L. J. Weller Osceola	Third Thursday 7:00 p.m.
Portage	H. A. Anderson River Pines Sanatorium Stevens Point	W. A. Gramowski 319½ Main Stevens Point	
Price–Taylor	E. B. Elvis Medford	J. J. Leahy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
Racine	L. M. Lifschutz 816 16th Racine	W. H. Williamson 1101 Grand Racine	Third Thursday
Richland	K. H. Meyer Richland Center	L. M. Pippin Richland Center	First Tuesday Richland Hospital
Rock	V. S. Falk 5 W. Rollin Edgerton	E. S. Hartlaub 19 S. Main Janesville	Fourth Tuesday
Rusk	M. L. Whalen Bruce	H. F. Pagel Ladysmith	First Tuesday
Sauk	M. F. Huth 203 Fourth Baraboo	J. J. Rouse Reedsburg	Second Tuesday*
Shawano	L. W. Peterson Shawano	A. J. Sebesta Shawano	Third Tuesday
Sheboygan	J. A. Russell Random Lake	R. M. Senty 1011 N. Eighth Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	D. S. Sharp 140 E. Main Mondovi	Robert MacCornack, Jr. MacCornack Clinic Whitehall	Fourth Tuesday
Vernon	P. T. Bland Westby	R. A. Starr Viroqua	Last Wednesday
Walworth	J. B. Schrock Sharon	W. C. Woods 607 Walworth Delavan	Second Thursday*
Washington–Ozaukee	J. F. Walsh 125 E. Main Port Washington	V. V. Quandt 57 S. Main Hartford	Fourth Thursday
Waukesha	James V. Bolger, Jr. 102 E. Main Waukesha	Philip Wilkinson 618 W. La Belle Oconomowoc	First Wednesday
Waupaca	Owen Larson Clintonville	H. S. Caskey Clintonville	
Winnebago	P. S. Emrich 456 Mt. Vernon Oshkosh	G. B. Hildebrand 216½ Main Menasha	First Thursday
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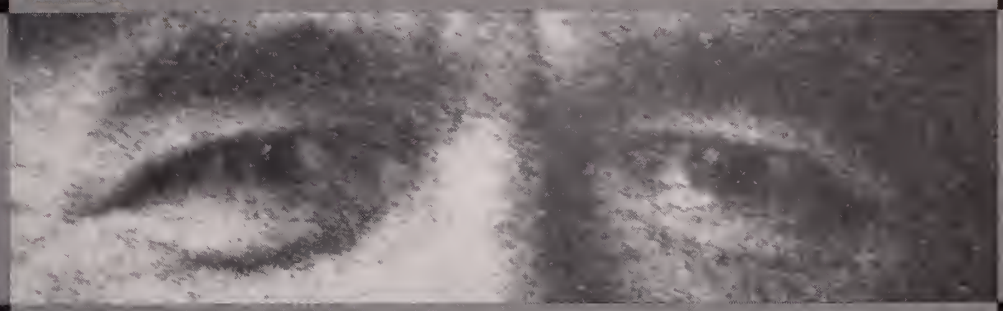

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Source—Hyman, M.: Some Aspects of Psychiatry in General Practice, GP *16*:83 (Oct.) 1957.

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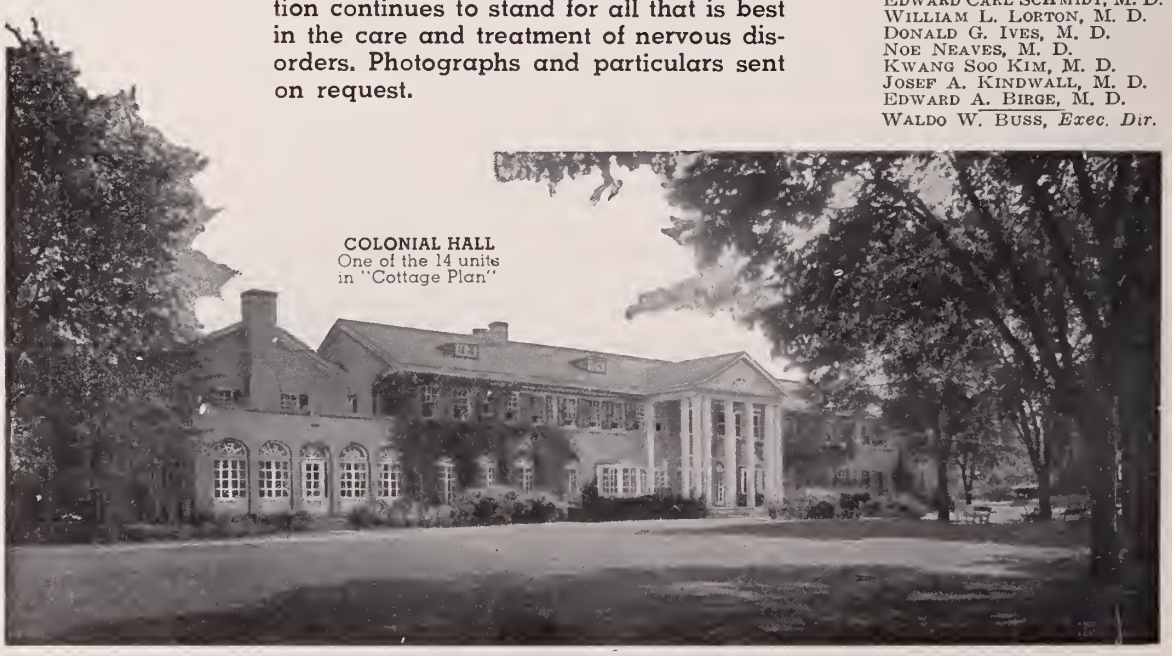

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Erythema Infectiosum

Report of an Outbreak in Marshfield, Wisconsin*

By KENNETH R. WILCOX, M. D.,** and ALFRED S. EVANS, M. D.***

Madison

DURING April and May, 1957, a disease manifested by a characteristic reticulated, erythematous, maculopapular rash occurred in children in Marshfield, Wisconsin. There was no fever, sore throat, coryza, or lymphadenopathy. At first these were thought to be cases with drug sensitivity although no specific drug could be implicated. As cases accumulated, it became clear that the disease was erythema infectiosum. Reports of the occurrence of a similar disease had come to the State Board of Health from Milwaukee, Racine, Kenosha, Watertown, Madison, Viroqua, and Shell Lake. This paper describes the clinical and epidemiological features of the disease as it occurred in Marshfield and presents the results of attempts to isolate the causative agent in tissue culture.

REVIEW OF THE LITERATURE

Erythema infectiosum, also known as the "fifth disease," was described around the turn of the century but has not received much attention since then. Tschamer is credited with the first description in 1886. He believed this to be a strange local variant of rubella in Graz, Austria. In 1889 Escherich described the disease and believed it to be a separate entity. The first paper in the American literature was in 1905 by Shaw,[1] who described an epidemic he had seen in Vienna. Since that time reports of cases have come from Norway,[2] the Netherlands, France, Austria,[3] Italy, Tunisia, Rumania, Turkey, Palestine, China,[4] Hawaii,[5] Uruguay, and Cuba. In the United States, reports in the literature have come of the disease occurring in almost all sections of the country since 1924.[6, 22, 29] The latest reports have occurred in Donelson, Tennessee,[19] and Reading and King of Prussia, Pennsylvania.[22]

The description of the disease probably has not been improved upon since Shaw's first description in English.[1] The following is extracted from his article:

> "A diagnostic feature of the disease is the character of the rash on the face, where it first makes its appearance. The cheeks are chiefly affected, and present a symmetrical rose-red efflorescence. The skin is hot to the touch, and is swollen, but it is not at all sensitive and does not itch. The color disappears on pressure, but quickly reappears. The whole appearance is suggestive of erysipelas. The eruption is confluent over the cheeks, and the edges are well defined, slightly raised, and distinct from the normal skin, but it may gradually fade on to normal skin. This area of confluent eruption is rather sharply limited in front by the nasolabial folds, and above by the temples. Laterally it extends to the angles of the jaws. The skin around the mouth appears pale in contrast to the livid hues of the cheeks. Discrete spots, varying in size from a pea to a hazelnut, are often seen on the forehead and chin. The rash fades from the face after four or five days. On about the second day the eruption makes its appearance on the body, where it is most marked on the outer surface of the arms and legs. The trunk is involved to a much less degree, and may be almost free, but in

* From the Wisconsin State Board of Health and the Communicable Disease Center, Public Health Service, U.S. Department of Health, Education and Welfare, and the Division of Preventive Medicine, University of Wisconsin Medical School. This investigation was supported in part by a research grant from the National Institute of Allergy and Infectious Diseases (E 1299), Public Health Service.

** Epidemic Intelligence Service Officer assigned to the Wisconsin State Board of Health.

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no case was the rash so intensive as on the face and extremities. The eruption spreads toward the periphery, and the hands and feet are the last portions of the body to be affected. On the extremities the exanthem is typical and characteristic. It is morbilliform in appearance, and not so deeply rose-red as on the face. The contour of the eruption presents frequently almost geographical outlines, and in many cases the appearance is suggestive of lacework, especially as it begins to fade at the end of the disease. On the inner or flexor surface of the arms the eruption is not nearly so intense. It is apt to become confluent around the outer surface of the elbow. On the legs the eruption is similar to that on the arms, and it is always especially well marked over the buttocks. The trunk remains comparatively free from eruption, although a number of discrete spots, sometimes crescentic in form, can be seen sparsely scattered over chest and back. The rash is more macular than papular, and shows only a slight elevation, except on the face, where it is always raised. An evanescence is often observed which is perhaps peculiar to this disease. The rash will apparently disappear when some slight irritation to the skin, such as friction, exposure to cold, etc., will bring it out again in full bloom."

In the literature, the course of the disease is usually divided into three definite stages: the malar flush, the spread to the extremities with some spread to the trunk, and the evanescent stage. During this last stage, the central clearing of the rash, particularly on the extremities and buttocks, to leave a garland or annular pattern, has been stressed by some authors.[2,7,11,12] Figures 1 and 2 demonstrate this. Even though some authors have noted that the rash is typical and almost constant,[6,11,14,21] frequently mild cases which have a rash of lesser extent but similar appearance are found to occur in association with more typical cases. Some have noted frequent absence of involvement of the face,[9–12,21] and in one series a number of "food rashes" involving the arms were reported from a school where erythema infectiosum was present.[6] In most cases in the literature the rash is macular or maculopapular, but occasionally vesicles, isolated papules, and other lesions are found along with the characteristic rash.[13,17]

Fig. 1—Left forearm of a two-year-old girl the third day of the rash, showing the garlandformed figures (from Boysen, G.: Erythema infectiosum, Acta paediat. 31:211–224, 1943, fig. 1).

Prodromata and symptoms during the rash are characteristically absent or mild. Prodromes of malaise, coryza, and sore throat have been noted but are not prominent. Low-grade fever is occasionally present and apparently related to the disease, as one longitudinal study has shown.[23] Cough, dizziness, and gastrointestinal disturbance are noted on occasion. The incubation period has been between 5 and 15 days.

THE MARSHFIELD OUTBREAK

The first cases were called to our attention on a visit to the Marshfield Clinic on April

Fig. 2—Second day of rash. Left arm, extensor surface, showing cleared central area which appears as rash extends to flexor surface (photograph of color plate from Lawton, Anne L., and Smith, R. Eloise: Erythema infectiosum; clinical study of epidemic in Branford, Conn., Arch. Int. Med. 47:28–41 (Jan.) 1931, fig. 3).

26, 1957. The physicians there kindly called 7 patients in for personal examination. These ranged in age from 6 to 9, and there were 3 affected members in one family. All children were afebrile and asymptomatic except for slight itching of the skin. The rash observed had two distinct patterns. Some children showed a diffuse erythema of the cheeks with a suggestion of perioral pallor. All had an erythematous macular papular rash primarily on the extremities but to some extent on upper chest and back. The striking and highly characteristic feature was a reticular, lacelike, or geographic appearance. This rash was transient, becoming more marked if covered by a warm hand or if the patient perspired. A few unimpressive posterior cervical nodes were present and in one patient the tip of the spleen was felt. There was questionable redness of the throat in a few. No conjunctivitis, Koplik's spots, pharyngeal exudate, posterior occipital adenopathy, or bronchitis was noted. The rash had a duration of 5 to 6 days and sometimes disappeared for a day or so in this period and reappeared. Throat and rectal swabs were collected.

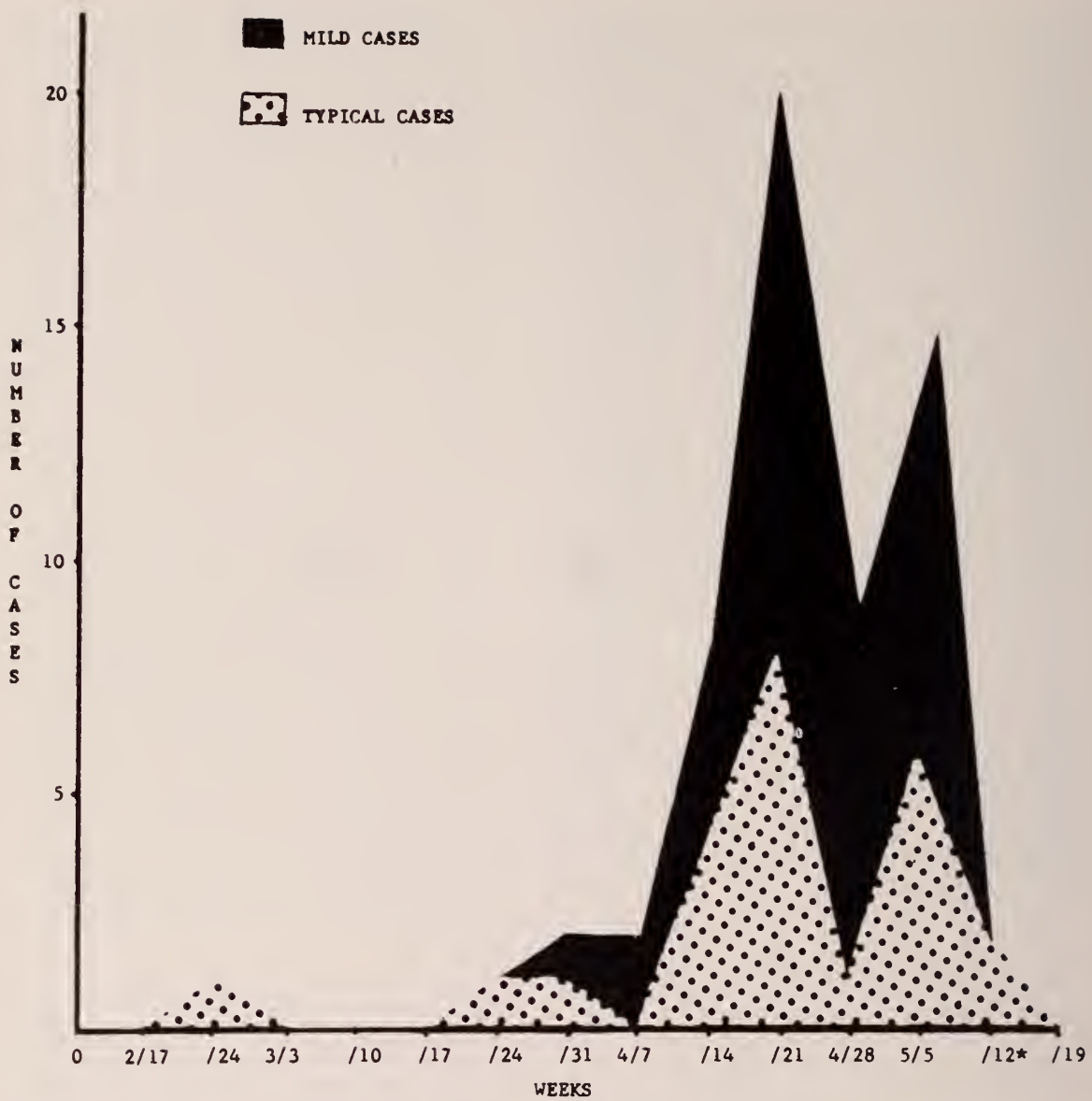
The diagnosis was unknown at this time and recent textbooks were not helpful. A review of older texts such as Osler's *Modern Medicine* (1913)[24] revealed excellent descriptions of the disease. These cases represented the stimulus for this study.

In order to ascertain the pattern of the disease in the community, a quick survey of the schools in Marshfield was taken. This was done by having each teacher ask how many of her pupils had had any rash during the past few months. The parents of those that responded were telephoned in order to determine the nature of the rash. Many rashes could be excluded as common rashes such as poison ivy, pustules, abrasions, etc. There was a group, however, whose description over the phone was so characteristic of erythema infectiosum that they are included in this study. The frequent comment was that it looked like beginning German measles that never really developed. Some likened the rash to beginning hives that never really developed. Many said that it was "under the skin" and used descriptive terms such as "lacelike," "irregular," and "patchy." It must be noted that any diagnosis of a skin eruption given over the phone is open to serious question, but under the circumstances this method enabled us to get some approximation of the incidence of the disease in the community. Since only three of the cases were current, not much would have been gained by home visits to those cases with no rash remaining.

In ascertaining duration of rash, date of onset, and other details some haziness of memory was encountered. The survey was taken two to four weeks after the peak incidence so this might be expected. This must be kept in mind through the discussion.

In all, 62 cases were found in which the rash was similar in description to erythema infectiosum. In addition, there were 4 children who were noted to have histories of rash in the past on exposure to sun. Two of these rashes were described as somewhat more urticarial than might be expected. One of the 4 children was compared by her mother to a playmate who had a more typical rash, and a definite difference was noted. These 4 cases will be excluded from the discussion of erythema infectiosum.

Of the 62 cases under discussion, 25 had typical pictures of rash involving the face, extremities, and usually the trunk. Eleven of



*Week of survey

Fig. 3—Occurrence of erythema infectiosum cases by week of onset, Marshfield, Wisconsin.

these were seen by members of the Marshfield Clinic, 3 were seen in the field during the survey, and 11 had histories of a typical rash as described by phone. These will be referred to as "typical cases." The remaining 37 patients had rashes with typical descriptions, but the extent of the rash as reported by the parents was less. Usually it was on the arms only, the arms and legs, and occasionally on the arms and trunk. These will be referred to as mild cases. In view of the literature cited above it may be justifiable to consider them as cases with the same level of confidence as the 11 more typical cases found by phone. This will be discussed further later.

EPIDEMIOLOGICAL STUDIES

Figure 3 shows the epidemic curves for the cases in Marshfield. It should be noted that a definite epidemic peak occurs and that the epidemic curves for both typical and mild cases is quite similar. The week of April 21 represents a week of vacation from school.

The week of April 28 represents return to school with resulting peak during the following week. The presence of this time relation in both typical and mild cases is suggestive of a communicable process.

The age range of the children was from two to sixteen years for both typical and mild cases. Forty-five (79%) of the fifty-seven children whose ages were known fell into the 5 to 14 age group. This, of course, was the school group and was the most intensively surveyed. This age distribution was similar to the previously reported general experience except that in some outbreaks a few adults have been noted to have the disease.[2,3,7,12,14,-18,19,21] No special effort was made here to find adult cases. There were 45 female and 15 male cases. A female predominance has been noted in some but not all outbreaks studied.[4,13]

The duration of the rash was from 1 to 14 days. The mean and mode both fell between 3 and 4 days. This is somewhat shorter than the usual 6 to 10-day duration noted in the literature. However, in three outbreaks in the literature there is noted a similar range and average duration.[9,13,23] The point can be raised that the poor observation powers of the parents may account for reports of the short duration of the rash. The mean duration of the rash in the milder cases was essentially the same as in the typical cases. It was noted in both the typical and mild cases that the rash tended to disappear and reappear during the course of the disease. It was not uncommon to pull a child's shirt up and observe a full-blown rash on his chest and abdomen that the parents were confident was not present 15 minutes previously. Parents also noted that the rash was usually less pronounced in the morning and that sun, exercise, or friction during the day would bring it out. Mild itching of the rash was noted in 13 cases.

Very few patients had symptoms associated with the rash. Malaise was noted in two patients and a low-grade fever that was not measured in one. Two patients had a slight cough associated with the illness. One patient was noted to have an "upset stomach" and one other had nausea and vomiting for one day, three days before onset. Our experience certainly agrees with the general impression that symptoms are usually mild or absent.

Two recurrences were noted but this study was not long enough to include late recurrences. One patient had the rash for one day and a recurrence one month later for four days. The face was spared the first time and involved during the recurrence. The other patient had a 3-day initial rash, a first recurrence 5 days later lasting one week, and a second recurrence two days after the first lasting 4 days.

There was no obvious geographic grouping of cases in the community. The method of collecting data did not yield complete enough information to warrant calculation of attack rates by schools. However, 29 of the 49 children that would be placed by school in the community attended the largest school (population 766). Fourteen attended two other schools (combined population 559). The remaining 6 were scattered among four schools (combined population 1,056), and five schools had no cases (combined population 1,363). The epidemic curve for the largest school is parallel to the total curve. The two schools with the largest number of cases were parochial schools drawing pupils from many areas of the community.

Multiple cases within a family unit were frequent. Of the 43 families involved, 34 had more than one child. Of these, half, or 17, had more than one case in a family. Table 1 summarizes these cases. In three families both

TABLE 1—MULTIPLE CASE HOUSEHOLDS

Family No.	No. of Children in Family	No. of Typical Cases	No. of Mild Cases	Siblings Without Rash	Interval Between Onsets of Cases if More than 1 Day
1	3	2	-------	1	--------
8	8	2	--------	6	14 days
16	6	2	--------	4	14 days
17	5	2	--------	3	------
25	5	3	------	2	----------
29	2	2	------	0	14 days
3	6	--------	2	4	----------
4	6	------	2	4	7 days
5	4	------	2	2	----------
26	3	------	2	1	----------
30	4	--------	2	2	12 days
31	3	-------	2	1	----------
37	3	-------	2	1	5 days
40	2	------	2	0	-------
15	6	2	3	1	--------
24	4	1	3	0	7 days
35	7	1	1	5	----------

typical and mild cases occurred. In one family 3 mild cases occurred one week after a typical case. This lends evidence to the supposition that these mild cases do actually represent erythema infectiosum. An estimation of incubation period from this of 5 to 14 days would agree in general with the literature.

LABORATORY DATA

Blood counts and cultures were not obtained in most of the cases under discussion. As reported in the literature the leukocyte, differential, and erythrocyte counts do not consistently show any marked changes in this condition.[7,13,14,19,21] Some cases have been reported with mild eosinophilia[3,5] Throat cultures were not done on the patients under discussion but have not proved helpful in the past.[7,11,13] One report of 12 cultures out of 37 containing beta-hemolytic streptococcus may be explained by the confusion on initial diagnosis with scarlatina and subsequent contact with scarlatina patients.[2] Antistreptolysin 0 titers in one series were negative.[19] Two biopsies are reported in the literature.[2,13] There was some perivascular cuffing with mononuclear cells, especially around the smaller plexuses of vessels in the skin, but this was neither characteristic nor diagnostic.

VIRAL STUDIES

The older literature mentions a possible viral etiology of this condition,[25, 26] but little definitive work had been done. Very recently an effort has been made to isolate the virus by Werner *et al.* in an outbreak in Reading, Pennsylvania, using modern tissue culture techniques.[22] Stool and throat washings were inoculated into monkey kidney cells. After 3 to 4 blind passages cytopathologic changes were seen consisting of multinucleated giant cells arranged in rosette fashion, and in stained cultures acidophilic intranuclear inclusions were seen. Great reservations must be made of these observations as representing the causative virus and not one inadvertently present in the monkey kidney cells. We have observed precisely similar changes following blind passage in monkey kidney cells of material from cases of infectious mononucleosis.[27] We have recently identified this as a virus antigenically similar to measles virus which we believe was present in the monkey kidney cells prior to inoculation. Ruckle[82] has seen similar changes of a measles-like agent in *uninoculated* cultures of such cells. More hopeful is the addendum to the paper by Werner *et al.*,[22] indicating possible isolation of a virus from another epidemic using human aminon cells.

In our experiment fresh, unfrozen throat washings and stool suspensions from 8 Marshfield patients were inoculated into human primary fibroblast cultures of uterus and foreskin tissue and also into a continual line of malignant human epithelial cells (Strain Hep–2). The results are summarized in table 2. No changes occurred in epithelial cells. In fibroblast cultures, rounding of cells, increased granularity, a few multinucleated giant cells, and questionable foamy areas were observed 10 to 11 days after inoculation. This went to diffuse involvement of most cells, sloughing of many from the glass, but with some preservation of the fibroblast pattern. Stained preparations showed similar changes, except that multinucleated giant cells were not seen. Intracytoplasmic and intranuclear inclusions were not observed. Pictures of unstained preparations are illustrated in figures 4 and 5. Since additional fibroblasts were not immediately available it was necessary to freeze the first passage at —20 C. for over three weeks before a second passage could be made. No cytopathogenic agent was then recovered in this second passage in a month's observation. Several unsuccessful attempts were made. We feel the cytopathogenic agent was probably labile and was lost as a result of freezing and storage. No additional studies could therefore be made.

The early results were very encouraging and we are most anxious to repeat these experiments again with fresh material if more cases are seen in the spring of 1958.

TABLE 2—RESULTS OF VIRUS STUDIES

Patient	Age	Day of Illness When Material Collected	Material Collected	Result in Tissue Culture of Human Cells	
				Fibroblasts	Epithelial
1	9	1st	Throat Swab	+	0
			Rectal Swab	+	0
2	10	2nd	Throat Swab	+	0
3	8	3rd	Throat Swab	+	0
4	6	5th	Throat Swab	±	0
			Stool	+	0
5	8	4th	Throat Swab	±	0
			Stool	0	0
6	8	1st	Throat Swab	±	0
7	9	1st	Throat Swab	0	0
8	6	1st	Throat Swab	0	0

Fibroblasts: Human foreskin and uterine tissue.
Epithelial: A line of malignant human cells originated by Moore at Sloan–Kettering Institute for cancer research, and termed Hep-2 strain.

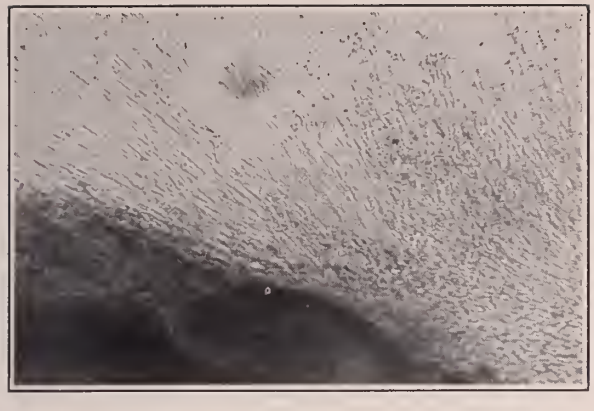


Fig. 4—Unstained living culture of normal human foreskin fibroblasts. Control tube for fig. 5, X 100.

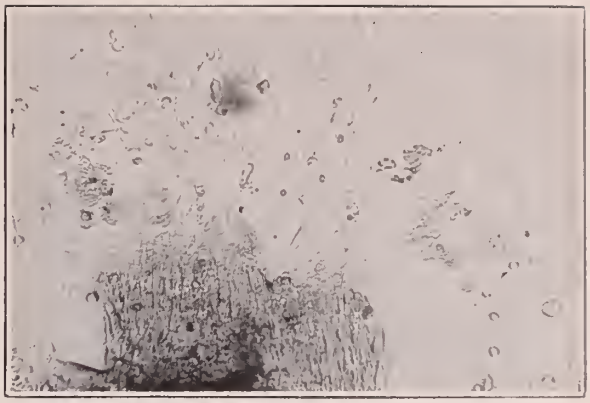


Fig. 5—Unstained living culture of human foreskin fibroblasts 7 days after inoculation with throat washings from patient with erythema infectiosa, showing rounding, granularity, and swelling of cells, X 100.

DISCUSSION

Erythema infectiosum would seem to be a well-established clinical entity. One of the chief reasons for the presentation of this data is to promote recognition and reporting of this disease. There are many problems presented by the disease which will probably remain unsettled until further identification of the etiologic agent is accomplished.

How common is this disease? The fact that a discussion about it does not appear in recent textbooks and that experienced practitioners cannot recall having seen it before leads one to believe that it is rare. However, it must be remembered that one would be hard pressed to make this diagnosis on a sporadic case without prior experience with the disease in epidemic form. We are well aware that cases of this disease have been diagnosed as mild rubella or allergy when they have been seen individually. The fact that, even though the secondary attack rate in families is fairly high, adults do not usually contract the disease is of interest. This could represent a lack of the occurrence of the rash in the adults when infected, or possibly failure to notice the rash. It is more likely that this indicates prior infection of a large portion of the adult population, with subsequent immunity to reinfection. The frequency of inapparent infections is not known but one would suspect that it would be high.

The State Board of Health is interested in obtaining reports of cases of this disease as soon as they occur. If an outbreak is detected early enough, a more adequate study may enable us to make an accurate clinical study and possibly isolate the etiologic agent.

This is apparently a benign viral disease, but we should learn from our experience with rubella that we should be cautious in assigning an infection to the "insignificant" role until its place in the spectrum of diseases is well studied.

No therapy has been effective and indeed none would seem indicated since the only symptom is a self-limited rash. There is no evidence that antibiotics would be effective because of the probable viral nature of the illness.

It is worth noting that there are several good pictures of the rash in the literature,[1, 2, 7, 8, 13, 14, 21] and in one reference a table of differential diagnosis is given.[24]

SUMMARY

Data on 62 cases of rash believed to be erythema infectiosum have been presented and the literature briefly reviewed. A cytopathogenic agent was obtained in human fibroblast cultures but lost on subsequent passage. More extensive reporting of this disease is encouraged in order to allow more adequate study of this interesting and rather elusive disease.

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Acknowledgment. The authors wish to thank the physicians of the Marshfield Clinic, particularly Dr. John Suits, Dr. Richard Rowe, Dr. James Vedder, and Dr. James Heersma. They are responsible for bringing these cases to our attention and have given valuable assistance to the study. We also wish to thank Mrs. Bolander, former public health nurse in Marshfield, who was of invaluable assistance in case finding and as a source of information about the community.

We are indebted to Dr. Milton Feig, Director of the Bureau of Communicable Diseases, State Board of Health, for his advice and support, and to Mrs. John Heim for her preparation of the paper.

WISCONSIN WOMEN PHYSICIANS ARE INVITED TO ATTEND THE SIXTH CONGRESS OF THE PAN AMERICAN MEDICAL WOMEN'S ALLIANCE IN MIAMI, FLA., APRIL 14–17

Purpose of the Alliance: ". . . to bring the medical women of North, South and Central American and the Caribbean area into an association for mutual improvement, encouragement of their participation in all branches of medical public welfare; for exchange of ideas and of improved treatment to facilitate social and cooperative relations; to assist in further education of its members through exchange fellowships and loans, and to generally forward such constructive movements as may be mutually beneficial and/or properly endorsed by the medical associations for our several countries." (Constitution, Art. II)

Post—Congress trips planned to the Caribbean and to Washington, D. C., April 18–20.

Inflammatory "Ringworm"*

By RICHARD J. ROWE, M. D.
Marshfield

INFLAMMATORY ringworm is a rather common condition in rural Wisconsin. This type of ringworm is called a kerion (fig. 1) when it appears in the scalp and tinea barbae (fig. 2) when it appears in the bearded area; the term tinea profunda is sometimes used to describe the disease occurring on other areas of the body.

SYMPTOMATOLOGY

The lesions are similar in appearance regardless of site. Erythema and scaling are the first signs of infection. Inflammation develops in two to four weeks. If the involved areas become edematous, the physician should warn his patient that the "deeper," more inflamed type of ringworm may be present. As the disease progresses, the involved area becomes more edematous, then follicular pustules appear over the surface of the lesion. The infection often progresses to form a nodular, boggy area with many draining sinuses. When the scalp is involved hair may be matted over the area. Even though fluctuation is present, attempts to incise and drain the nodules are often not successful because of the boggy nature of the tissue. Hair in the area tends to break off and may be pulled with ease. Enlarged, tender, regional lymph nodes are usually present. Not infrequently the temperature is elevated, and occasionally a generalized, papulo-erythematous eruption appears (trichophytid). The disease runs its course in two to four months but may last longer in some cases.

At least in the early stages the inflammation seems to be primarily an allergic reaction to the tinea. When pustules and drainage occur, secondary bacterial infection may be present.

DIAGNOSIS

To establish a diagnosis place scales or hair from the involved area on a microscopic slide, apply a drop of 15% KOH solution, a cover slip, heat the preparation just short of boiling, then apply pressure to the cover slip in order to facilitate microscopic examination. If spores or mycelia are present, a positive diagnosis can be made, but the converse is not necessarily true. Particularly in the latter stages of the infection it may not be possible to demonstrate spores or mycelia in spite of repeated efforts.

Fig. 1—Kerion celsi. Note enlarged postauricular lymph node.

Fig. 2—Tinea barbae.

*From The Marshfield Clinic.

DIFFERENTIAL DIAGNOSIS

Acute bacterial infection must be differentiated, and this may be particularly difficult in the scalp and beard. Tineal infection is patchy in distribution while bacterial folliculitis is more likely to be diffuse. In tineal infection the involved hair is loose and tends to break off but does not fluoresce under the Wood light as seen in epidemic tinea capitis. If the course of the disease can be followed, diagnosis eventually becomes evident. However, unless the diagnosis is made early and the patient warned about what to expect, he often becomes impatient with the results of therapy and may consult another physician. Inflammatory ringworm has also been confused with blastomycosis. Blastomycosis, a deep mycosis, is a more serious disease; the cutaneous form may appear as a chronic patch of granulation tissue which is purulent, verrucous, and crusted. There is often central clearing with scar formation. Pustules are present around the edge of the lesion from which the budding organism may be identified microscopically.

REVIEW OF CASES

Fifty-eight cases of inflammatory tinea seen at the Marshfield Clinic during the past six years were reviewed. The ages of the patients varied from two months to 62 years. Of this group 39 were males and 19 females. Under the age of 14 years there were 16 of either sex, but of those 14 years and older there were only three females. This type of infection is thought to be contracted from animals but not to be very infectious from one person to another. Under the age of 14 years children of either sex would be expected to have about the same exposure to farm feeds and livestock. Men have more exposure than women as ages progress. The adult scalp resists ringworm infection, but the male beard is very susceptible.

Fifty of the group lived on a farm and four lived in town. Of the four who lived in town one was a veterinarian's daughter and two had visited a farm before becoming infected. The place of residence of the remaining four is unknown.

Forty-four of the infections occurred during the first six months of the year and 14 during the second six months. The average duration of the infection at the time of the patient's first visit to the clinic was about three weeks. There was only one case each in August and September, two each in October and November, three in December, and 12 in January. Ringworm also occurs much more frequently in livestock during the winter months when animals are kept inside.[1]

TABLE 1.—LOCATION OF LESION WITH RESPECT TO AGE AND SEX OF PATIENTS

Age	Sex	Scalp Infection (Kerion Celsi)	Beard Infection (Tinea Barbae)	Other (Trichophyton Profunda)
Under 14 yrs.	Male	14		2
	Female	14		2
14 and over	Male		20	3
	Female			3
Total		28	20	10

Microscopic examination was not performed in all cases, but mycelia or spores were found in 38 of the 58 patients. Cultures were done in about 22 of the cases. *Trichophyton gypsem* was identified in only four cases. *Trichophyton verrucosum* frequently causes cattle ringworm. We use Sabouraud's media, on which *Trichophyton verrucosum* does not grow well.[2] This may be one reason why we did not have better results with cultures. It is true that the specific organism cannot be identified without cultures but identification is not necessary for clinical diagnosis or treatment.

CASE PRESENTATION

A 50-year-old white farmer was seen on January 2, 1957, complaining of scaling and erythema of his face of about two weeks' duration. Scales removed from the area and prepared as previously described were examined under the microscope. Many mycelia were present. The patient was treated with a fungicidal ointment and seemed to improve, but on February 12 he noted that his face began to swell, and on February 14 the areas became edematous and pustule formation was noted. He entered the hospital on February 19 with acute erythema, edema, and pustule formation involving the left side of his face. There was a similar eruption in scattered areas on his neck and the right side of his face. His temperature was 99.2 F., hemoglobin 15.2, white blood cell count 17,200 with 79% segmented neutrophils, 9% stabs, 9% lymphocytes, and 3% monocytes. Blood pressure was 120/70 and pulse 88. The serological test for syphilis was nega-

tive. During hospitalization the patient improved slowly on tetracycline, 250 mg. four times daily, and bland local therapy. At the time of discharge on February 25, 1957, there was little drainage and the edema was receding nicely. Heavy crusting was still present. The patient was seen as an outpatient on March 7, at which time most of the edema had receded but erythema and scaling was present. The patient was last seen on July 16, 1957, at which time slight erythema and scarring was present on the left side of his chin and face. There was no edema, and there were no palpable nodes.

DISCUSSION

The time lapse between the patient's first awareness of infection and the onset of acute inflammation was about two months. The acute reaction lasted for about four weeks. For practical purposes the patient felt that his eruption had cleared about three months after its initial appearance. There was erythema and scarring seven months after the onset. Once the allergic response has developed and the acute reaction appears, further spread of the infection is not to be expected. However, it is at this time that the trichophytid reaction may appear.

TREATMENT

This is a self-limited infection. The inflammation is primarily an allergic response to the infecting ringworm. The infection extends deeply into the tissue and may even be cultured from the local lymph nodes. Under these conditions presently available fungicidal drugs, local as well as systemic, are not satisfactory. Therefore, therapy is palliative and only mild treatment should be employed. During the acute draining stage hot, wet compresses using Burow's solution (Domeboro, one packet to one quart of water) should be applied three times daily. On the scalp we use 1% iodochlorhydroxyquin (Vioform, Ciba) three or four times daily. On other areas 1% hexachlorophene (G–11) in calamine liniment is useful. As the drainage subsides, 2% iodochlorhydroxyquin in yellow petrolatum is applied three times daily. This type of therapy helps to prevent secondary infection. If the temperature is elevated and secondary bacterial infection seems to be present, antibiotics are indicated. If a trichophytid eruption occurs, antihistamines may be of some value. Reassurance is usually the most important therapy.

On the scalp and in the beard the hair in and around the area should be cut short to prevent matting. Because the inflammation is deep, hair follicles may be damaged, resulting in varying degrees of alopecia and scar formation. Some degree of scarring may remain indefinitely.

SUMMARY

Inflammatory ringworm is quite common in rural Wisconsin. The disease is described. Fifty-eight cases seen at the Marshfield Clinic are reviewed and one case is presented. This infection is a frightening experience for the patient and his family but is self-limited; the most important aspect of therapy is reassurance.

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TRUDEAU SOCIETY MEETING

A discussion of radiation by Dale E. Trout, General Electric Company X-ray department and S. A. Morton, M.D., radiologist, Columbia Hospital, Milwaukee, will highlight the annual meeting of the Wisconsin Trudeau Society, Saturday, April 26, 1958.

Other speakers include Joseph Gale, M.D., Madison; Anthony Curerri, M.D., Madison; Quinton Callies, M.D., Madison; George M. Maxwell, M.D., Madison; and Ross Kory, M.D., Wood.

MINNESOTA CONTINUATION COURSES

A series of medical continuation courses are scheduled for presentation at the Center for Continuation Study, University of Minnesota:

April 14–16—Gastroenterology for General Physicians

May 5–9—Electrocardiography for General Physicians and Specialists

May 12–16—Proctology for General Physicians

For further information, write Director, Department of Continuation Medical Education, 1342 Mayo Memorial, University of Minnesota, Minneapolis 14.

Nonfatal Farm Accidents

Report of a Pilot Study and Review of the Literature*

By LEROY G. WALSH,** THOMAS H. F. CHALKLEY,** and ALFRED S. EVANS, M. D.***

IN 1954 fourteen thousand farm residents died as a result of accidents, 3,800 of which were incurred in the pursuit of farm work. This is more accidental deaths than occurred in any one industry in the United States and the death rate per 100,000 workers ranks second only to that in mining and construction. In the same year 1,200,000 farm residents had injuries which caused disability of one day or more, a rate of about 4,000 accidents per 100,000 farm residents. About one-fourth of these were as a direct result of farm work.[1]

During the year 1948, 17 million work days were lost as a result of farm accidents, an average of 20 days per nonfatal accident.[2] Other losses such as property damage, costs of extra hired help, loss of income, grief to the victim's family, and the extra financial and work burden imposed upon it, as well as physical and mental anguish to the victim himself, have not been estimated, but undoubtedly they are enormous.

In 1948, according to estimates of the U. S. Bureau of Agricultural Economics, more than $36,000,000 was spent for medical, dental, and hospital care for farm-accident victims. Medical care cost about $43 per accident, only one-fourth of which was covered by insurance.[2]

Recognizing the enormity of this farm accident situation, the Division of Preventive Medicine of the University of Wisconsin Medical School has undertaken an investigation. The present pilot study had two purposes: (1) investigation of methods that might be used in a later larger study; (2) careful evaluation of a few accidents by immediate interview to ascertain not only the possible causes but also the social and financial impact of the accident on the farmer and his family.

REVIEW OF THE LITERATURE

Table 1 summarizes the population group involved in previously reported studies of nonfatal farm accidents as well as the present study. With the exception of the investigation of the United States Department of Agriculture reported by Senf,[2] no data are available on the actual incidence of nonfatal farm accidents. The Agriculture Department found 1,927 nonfatal accidents per 35,892 farmers interviewed or 53.6 per 1,000.

Repeated reference will be made to the surveys tabulated in table 1 in order to compare various features of previous studies with those of the present investigation.

MATERIALS AND METHODS

In a preliminary survey it became evident that certain restrictions and limitations on the project, as well as definition of pertinent terms, were a necessity. It was decided to review only accidents occurring in or about Dane County, Wisconsin, between the dates of April 15 and September 1, 1956. It was decided to investigate only those accidents for which competent medical assistance was sought. To this end the aid of the Dane County Medical Society was solicited and gratefully received, its members notifying us of any farm accident victims treated between said dates.

Certain commonly used terms needed defining. For the purposes of this survey the following definitions seemed particularly applicable and reasonable. A farm is "any piece of land used for commercial agricultural purposes." A farm accident is "any mishap

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We would like to express our deep appreciation to the physicians of Dane County who cooperated in this study. Without them it could not have been carried out. We also wish to thank Dr. John Z. Bowers, Dean of the University of Wisconsin Medical School, for suggesting this study and for his support in its execution.

TABLE 1—SUMMARY OF STUDIES OF NONFATAL FARM ACCIDENTS REPORTED IN LITERATURE

Authors	Reference	No. of Cases	Basis of Case Selection	Years Studied	Area Studied	Method of Analysis
Powers	15	310	Treated at Mary Imogene Bassett Hospital	1929–1938	Rural area, New York State	Study of hospital records
Calandruccio and Powers	5	658	As above	1929–1948	As above	As above
Young and Ghormley	10	575	Treated at Mayo Clinic	1935–1943	4–5 counties in Rochester, Minnesota	As above
Creevey	3	370	Admitted to Mary McClellan Hospital	1920–1940	Around Cambridge, New York	As above
Snyder	11	25	Admitted to Snyder Clinic and Wm. Newton Memorial Hospital	1951–1952	Rural area near Winfield, Kansas	As above
MacCornack	18	333	Treated at MacCornack Clinic	1945–1946	Rural area near Whitehall, Wisconsin	As above
Senf	2	1,927	Interviews of 35,892 farmers	3 mo., 1946 9 mo., 1948	Countrywide	Interview and questionnaire
Present study	--	66	66 of 104 cases who sought medical care from doctors or hospitals in Dane County	Summer, 1956	Limited to Dane County, Wisconsin (about 9,000 farmers)	Questionnaire, interview, on-the-spot investigation

occurring on or about the farm resulting in injury to the body of the victim, the extent of which requires him to seek medical aid." Medical aid is defined as "treatment of an individual by a medical doctor or by a qualified member of the staff of an approved hospital." It should be noted that most previous studies have defined a farm accident as one in which the victim was *"disabled"* for a period of one day or more.

Only 35 members of the Dane County Medical Society practice in rural communities (outside the city of Madison). Of these rural doctors, 19 indicated that they saw farm accidents and would cooperate in the survey. Their importance was demonstrated by the fact that, though they represented only 26% of the physicians who treated farm accidents, nevertheless they contributed 73% of the cases investigated during the survey.

Each reported accident was investigated personally as soon as possible by one of two junior medical students conducting the field survey. A form questionnaire was filled in during each interview. Emphasis was placed on an evaluation of accident causation as well as on an estimation of both social and economic impact on the victim, his family, employer, and associates.

Using the system just outlined, 66 cases of 100 reported to us were investigated during a two-month period. Thirty-four reported cases were not investigated for various reasons.

An attempt was made to parallel previous investigations as much as possible, extending the inquiries to include categories which might be significant, but on which no previous data had been published.

RESULTS

The Accident in General

The results of the survey are compared in tables 2, 3, 4, 6, and 7 with the results of similar studies. 72.7% of the accidents occurred while the victim was engaged in farm work, and 19.7% occurred during recreational activities. Housework, carpentry, and others accounted for 7.6%. Activity of the victim at the time of the accident is shown in table 2.

Almost 55% of all reported accidents occurred in the barn or farmyard. Thirty-two percent occurred in the fields and 8% in the house or shed; 3% occurred on the highway and elsewhere on the farm (table 3).

TABLE 2—PERCENT DISTRIBUTION OF ACTIVITY ASSOCIATED WITH FARM ACCIDENTS IN PRESENT STUDY AS COMPARED TO THAT IN PREVIOUS REPORTS

Activity	Calandruccio and Powers[5]	Creevey[3]	Powers[15]	Present Survey	Average
Chores	30.6	34.9	31.9	39.4	34.1
Logging	17.6	13.8	21.3	1.5	13.6
Haying	15.9	14.1	16.1	27.3	18.4
Play of Children	16.1	19.7	10.0	18.2	16.0
Repair and Construction of Buildings	4.1	3.2	7.1	4.5	4.7
Assault or Suicide	3.3	4.3	4.2	-	---
Machinery Repair	---	---	---	10.6	---
Other	12.1	10.0	9.4	1.5	8.3

TABLE 3—PERCENT DISTRIBUTION OF LOCATIONS OF FARM ACCIDENTS IN PRESENT STUDY AS COMPARED TO THAT IN PREVIOUS REPORTS

Place of Accident	Calandruccio and Powers[5]	Creevey[3]	Senf[2]	Present Study	Average
Barn or Barnyard	50.8	48.9	21.6*	54.5	44.0
Field or Pasture	21.5	17.6	----	31.8	17.7
House and Shed	7.5	17.0	15.9	7.7	12.0
Highway	4.4	----	11.4	3.0	4.7
Woods	11.0	7.6	----	----	4.7
Elsewhere on Farm	----	----	34.2	----	8.6
Other	4.8	8.9	16.8	3.0	8.4

The Agent

The most important physical cause of accidents was the machine, which accounted for 25 accidents or 38% (table 4). Balers were the most common machine responsible, and tractors came next. Power saws and electric water pumps were involved twice, and a wide assortment of farm equipment from manure spreader to corn picker was associated at least once with other injuries. Obviously, the season of the year and the type of farming will dictate the machine in most common use and thus associated with more accidents, but the tractor deserves special mention for respect and caution.

Both the age of the machine and familiarity with it may be of importance. In this study the age of the implements varied from one-fourth to 12 years with an average of three years. In two instances the machines were being used by the victim for the first time, and in four instances were over 10 years old and in poor condition. Thus six, or nearly one-fourth of the accidents with machines, could have been avoided by instruction in the proper use of equipment and by proper maintenance.

The second large category of causes was falls, accounting for 18 injuries or 27%. Almost half of these were from hay wagons or tractors. Three falls occurred from a tree and one from a ladder. Except for the exercise of more caution and perhaps of guard rails in some instances, these would be hard to prevent in a specific way.

Animals were responsible for the third group, accounting for 9 accidents or 13.6%, and cows were responsible for half of these. The average age of the animals was four years. Other categories were farm tools (7.6%) and falling objects (6.1%).

In reviewing the information on causation, two points deserve emphasis. First, in 29 of 66 accidents the victim was either totally unfamiliar or only slightly familiar with the object that injured him. In four instances, someone else on the farm had had similar difficulties with the same object and the victim was aware of the hazard involved. Education and common sense would have prevented many of the accidents.

The Environment

Weather appeared to have little effect on accidents during this 4½-month period. Weather was good in 88% of the cases, and the elements seemed to have a direct bearing on the accident in a maximum of 5% of all

TABLE 4—PERCENT DISTRIBUTION OF AGENTS ASSOCIATED WITH FARM ACCIDENTS IN PRESENT STUDY AS COMPARED TO THAT IN PREVIOUS REPORTS

Agent	Calandruccio and Powers[5]	Young[10]	Creevey[3]	Senf[2]	Powers[15]	Present Survey	Average
Machine	13.3	32.4*	15.7	12.8	12.9	37.9	20.8
Animal	16.0	18.1	13.5	12.1	16.5	13.6	15 0
Tool or Implement	15.7	2.3	13.3	7.8	18.1	7.6	10.8
Vehicle	9.7	----	7.8	9.3	11.6	----	---
Falling Object	4.9	2.3	4.3	5.3	5.5	6.1	4.7
Heat or Cold	2.9	----	5.6	----	2.2	----	---
Falls	---	33.5	----	24.7	----	27.3	--
Fire or Burns	----	2.6	----	4.2	----	1.5	---
Handling Objects	----	----	---	8.3	--	----	----
Stepped-on Objects or Striking Against Objects	---	----	---	7.6	-	3.0	----
Others	37.2	8.8	39.6	7.9	33.2	3.C	----

*All machinery.

cases. In only one case was weather and weather alone the etiological agent.

There was only one case in which insufficient lighting played a part in the accident, this occurring when a farmer attempted to fix a machine in a dark shed without artificial lighting. There were 6 cases in which artificial lighting was used and seemed adequate for the job. The sun was shining brightly in 51 cases and the victim admitted the light was good for working.

Temperature did not appear to be a factor in any of the cases although the person injured stated in seven instances that it was "very hot."

Terrain proved to be a causative factor in 19 instances, 13 in falls. Lay of the land was also a factor in three machine accidents, two falling object mishaps, and in one case of a stepped-on nail. In 47 cases, terrain did not appear to be a factor in the accident.

TABLE 5—PRIMARY PRODUCTS OF THE FARMS ON WHICH THE ACCIDENTS INCLUDED IN THE PRESENT STUDY OCCURRED

Products	Primary Product	Secondary Product	Tertiary Product
Dairy	46	2	0
Swine	3	27	6
Poultry	0	5	8
Beef	6	3	2
Grain	5	12	2
Vegetables	2	1	0
Sheep	1	2	1
Mink	1	0	0
Breeding Cattle	1	0	0
Fruit	1	0	0

A second individual was directly involved in the accident in 40% of all cases, which would seem to indicate that one person's carelessness or neglect often results in another's grief.

Time of day would seem to have a definite relationship to the incidence of farm accidents. There is a definite mid-to-late morning and mid-to-late afternoon increase of accidents with peak hours of 11 a.m. and 5 p.m. There were no accidents reported between 8 p.m. and 6 a.m.

The Host

The youngest victim was 2 years of age, the oldest 74 years. The average age of victims was 30 years; the mean age was 25. It is significant that 16 victims were under 18 years of age and that there were only 2 victims in the 40-to-50-year-old age bracket.

Fifty-six of the victims were males. Of the 10 females 7 were under age 16 and 2 were over age 67. There was only 1 female victim between the ages of 16 and 67.

In planning this survey it was thought that the education of the victim might be a hidden factor in the incidence of farm accidents. Our statistics did not support this supposition, although it was also not disproven. Forty-six of the victims had an eighth grade education or more, 14 had graduated from high school, and 1 was a college graduate. Only 7 adults had had no formal schooling.

Of perhaps even greater importance than general schooling is farm safety education. Only 13 of the 66 victims had had any formal farm safety education, 5 of these in Future Farmers of America and 4 in 4–H work. Two had had some safety aspects stressed in high school agriculture courses. Two persons had attended University of Wisconsin agricultural short courses which had put some stress on farm safety and farm accident prevention.

Eleven of the injured had less than one year of previous experience on the farm. Eleven others had less than 5 years of farming experience. The average was 19.7 years experience and the mean was 15 years.

Accident-proneness, a relatively new concept in the field of accident prevention, proved difficult to evaluate. In only two cases did the interviewer feel the victim to be definitely accident-prone, based on objective and subjective findings. Objectively, 43 of the victims had never had a major accident during their lifetime. Seventeen had had one major accident, 4 had had two, and 2 had previously had three major accidents. Sixty of the victims could not remember having an accident of any type in the three months prior to their accident. Five remembered having one slight mishap and 1 had had three accidents in the preceding three months.

There had been no fatal accidents on the farms of any of the victims in the last five years. In the three months preceding the interview persons other than the victim had had 16 accidents on the farm requiring medical attention. In four cases there were 2 such accidents in the preceding three months.

Forty-five percent of those interviewed stated that they were definitely in a hurry at the time of the accident. Eighteen accidents occurred after the working day was done,

while 3 accidents occurred within the first hour of work; 12 victims stated that they were very tired at the time of the accident.

Lack of sleep was a possible contributing factor in 2 cases, the victims getting only four and five hours of sleep respectively the night before the accident. Fifty of the victims had gotten more than eight hours sleep preceding the accident. Ten persons said they had less than the normal amount of sleep, and only one had not slept soundly.

Drugs and medications were not a causative factor. Four of the victims were in poor health at the time of the accident. One had Perthes' disease, one had an amputated left arm, one had severe arthritis and troublesome ulcers, and a fourth had severe arthritis as well as clubbed feet. Three others were considered to be in fair health even though they had heart trouble, extreme obesity, and slipped disk. Only one of the victims had recently been troubled with dizziness but didn't notice any difficulty on the day of the accident.

Sixty-eight percent of the victims had good vision without glasses, thirty percent wore glasses to correct poor vision, and one victim had faulty uncorrected vision. Defective vision did not seem to be a factor in any of these cases.

Hearing was good in 63 of the cases. Two victims admitted that their hearing was poor, and one said his hearing was only fair. Defective hearing did not seem to be a factor in any of the cases.

Eight victims felt that income was an indirect factor in the accident, 5 stating that insufficient income made it impossible to hire badly needed help and 3 stating that they could not afford new, safer machinery.

Personal factors are always difficult to evaluate, but with the assistance of the victim's family and acquaintances as well as impressions given to the interviewer, several points were brought forth that may be of significance. Twenty-nine of the victims were judged to be habitually careless, 22 as daydreamers, and 21 as being quite impetuous in their actions and decisions. Thirteen were noted to have difficulty controlling their tempers, but none of these was known to have had any difficulty on the day of the accident. Eleven were classified as being quite forgetful and 6 as being disorderly; 4 were habitual users of alcohol, though not alcoholics, and none of these was definitely known to have had any alcohol on the day of the accident. Two of the victims were probably below average in intelligence.

Eleven victims felt they were under mental stress at the time of the accident. Four said they were preoccupied with business matters, 3 were worried about too much work, 2 were excited, 1 was mentally depressed, and 1 was worried about family problems. A twelfth victim said he was bored with his work when the accident happened.

In 9 cases the victim had had some warning prior to the accident. Three were warned verbally to be careful, stop their activity, or remove the hazard in another way; 4 heard warning noises such as a creaking limb or the sounds of an excited animal. One victim had just warned a second person to beware of the same hazard, and still another failed to get out of the way after anticipating the action of an excited animal.

CONSEQUENCES OF THE ACCIDENT

In considering results of the accident it is interesting to note that 25% of the victims never received tetanus prophylaxsis, either before or during treatment for the accident.

TABLE 6—PERCENT DISTRIBUTION OF TYPES OF INJURIES SUSTAINED IN FARM ACCIDENTS IN PRESENT STUDY AS COMPARED TO THAT IN PREVIOUS REPORTS

Type of Injury	Calandruccio and Powers[5]	Creevey[3]	Powers[15]	Present Study	Average
Fractures	31.7	50.0	33.7	30.3	36.4
Amputations	8.2	14.0	10.6	7.7	10.1
Lacerations	14.2	10.3	14.5	27.3	16.6
Gunshot	0.9	6.0	0.6	1.5	2.3
Burns	2.9	5.3	3.5	3.0	----
Frostbite	2.9	0.5	3.5	---	----
Contusions and Abrasions	12.5	4.0	14.9	15.1	11.6
Dislocations	4.1	3.0	4.1	---	---
Puncture Wounds	7.0	2.0	7.4	10.6	6.8
Concussions	4.8	1.5	4.1	--	----
Foreign Bodies	1.4	0.8	0.5	--	-
Others	12.2	2.8	7.1	4.5	---

Table 7—Body Distribution of Lesions Sustained in Farm Accidents Included in the Present Study as Compared to that in Previous Reports

Location of Injury	Creevey[3]	Powers[15]	Present Study
Head and Neck	12.5	22.8	15.1
Arm and Shoulder	39.8	36.9	40.9
Trunk	14.3	10.4	6.1
Leg and Hip	30.3	23.5	22.7
Genitalia and Perineum	--	0.9	--
Multiple and Shock	4.3	5.4	15.1

Table 8—Contributing Activity in Accidental Farm Fatalities as Tabulated From Previous Studies

Contributing Activity	Powers[15]	Calandruccio and Powers[5]
Chores	31	37
Logging	25	21
Haying	19	21
Playing Children	13	11
Repair of Buildings	6	5
Suicide	6	5

Thirty-three percent received tetanus antitoxin; 17% had had a booster dose of toxoid a short time previous to the accident; and another 17% received a booster dose at the time of treatment.

The major lesions suffered as a result of the accidents were fractures (30%), lacerations (27%), contusions (15%), puncture wounds (11%), and amputations (8%) (see table 6). Forty-one percent of these were lesions of the upper extremity and 23% of the lower extremity; 15% affected the head and neck, 15% were multiple injuries, and 6% were lesions of the trunk (see table 7).

Eighty percent of these cases required no hospitalization. The other 20% (13 cases) were hospitalized a total of 189 days, an average of 14½ days, with a mean value of 7 days. The longest period of hospitalization was 45 days and the shortest was 1 day.

Forty-five victims suffered at least one day of total disability. The average was 12 days and the mean 2 days. In 14 cases the wounds were so slight that they failed to result in even partial disability. A total of 1,391 days of partial disability resulted from these 66 accidents, an average of 21 days per accident, and a mean of 14 days.

In 7 cases extra hired help was needed to carry on the normal work of the injured person. This help was necessary for a total of 235 days, an average of 33 days per accident, at a total cash cost of $1,539, or $220 per accident. Property damage resulted from only three accidents, amounting to $603 in repair bills. These costs were in addition to medical and hospital bills as well as other costs adequately covered by insurance.

In 17 cases the victim had no insurance to pay for hospital or medical bills. Thirty victims had total insurance coverage, and 19 others were partially covered. In one instance a private donation of $115 covered 20% of medical costs. The United States Army paid total costs in one case, and the medical bills of an orphan victim were paid by Dane County.

The present study included no fatal farm accidents. The findings of previous studies of fatal farm accidents are summarized in tables 8 and 9. Generally these would seem to parallel findings in morbidity studies.

DISCUSSION

From our experiences and the literature reviewed it is readily apparent that there are a number of factors which are important in the causation of farm accidents. Farming is by its nature a hazardous profession. Without any special training the farmer is required to be a Jack-of-all-trades. He is a businessman, an animal trainer, a lumber-

Table 9—Percent Distribution of Causes of Accidental Farm Fatalities as Tabulated From Previous Studies

Contributing Agent	Snyder[11]	Calandruccio and Powers[5]	MacCornack[18]	U. of W.[23]	Rush[24]	Kansas[30]
Machines	33	7	-	41	22	46
Animals	18	19	--	15	13	10
Falls	11	--	60	7	8	8
Vehicles	9	13	20	9	20	15
Excess Heat	6	19	--	--	4	-
Lightning	6	--	--	2	5	4
Burns and Fire	4	--	--	4	8	4
Falling Objects	--	13		5	3	4
Firearms and Explosives	--	7	--	4	3	--
Other	13	25	20	13	14	9

jack, a carpenter, painter, mechanic, plumber, machinist, and planter. Necessity often requires him to use makeshift tools and equipment. Because of low income and the high cost of modern machinery, he is often forced to use obsolete and unsafe equipment. Because he can afford only a meager wage for additional help, he must often make the best of insufficient or incompetent hired hands.[3] As a result he often is forced to work many long, hard hours daily with little time for rest and relaxation. After weeks or even months of little more than eat, sleep, and work, his life easily becomes filled with boredom due to the monotony of his existence. Hence, the statement, "Mental depression is more common among rural workers," is found in some psychiatric textbooks.[4]

In contrast to people in most other industries the farmer is not required by law to provide safety devices for his machines or to carry hospital or accident insurance, even though farming is one of the most hazardous of all occupations.

Accidents during the use of machinery are sometimes the result of failure of the manufacturer to equip his machines with proper safety devices, such as protective shields or automatic shut-off levers. But even more frequently machinery accidents are the result of improper procedures and unwise practices by the operator. Repairing or unclogging a running machine is an extremely common, though absolutely unnecessary cause, of many accidents. The practice of using a machine, such as a tractor, to do jobs for which it was never intended results in many mishaps. "The farmer uses the tractor in very much the same way as a child uses a tricycle. It is not only used for many actual farm duties, but also as an ordinary mode of transportation,"[5] a use for which it was not designed. This practice often results in accidents on the highway which never would have happened if the proper vehicle, a truck or automobile, had been employed.

To the previous hazards may be added the factors of personal carelessness and recklessness, major factors in the causation of many accidents of all kinds.

Old age seems to play an important role in farm accidents. According to statistics the greatest number of farm work fatalities occurs in the 60-to-69-year age group. The second largest number of fatalities is in the 50-to-59-year-old group.[6]

Children are also involved in a great number of farm accidents. We believe this to be due largely to the common practice among farm families of allowing children, 5 years and older, to help with farm work. This includes driving tractors, running assorted machines, handling animals, repairing fences, and doing virtually all activities performed by the farmer.[7] This is a most dangerous practice. Tractors were not designed for children. It requires experience and maturity to operate a complicated hay baler. Strength is a necessity in handling an unruly animal. It is common for farm children to play around machinery, men at work, livestock, and in the farm buildings. As a result, many children's games end in a fall from the haymow, a blow on the head from a falling milk can, a kick from a cow, or with the child pinioned beneath the wheel of a tractor.

Fatigue is a factor of importance in a large number of accidents. This is partly a result of failure to observe rest periods and partly due to the fact that a machine, unlike a horse, does not require rest and consequently may be run without stopping for many hours at a time. It is not unusual for a farmer to spend 10 hours a day in a field riding a tractor. Even darkness is no longer a deterrent to further work, for most tractors now come equipped with powerful lights. Sometimes even meals are forgotten or neglected in the press of work.[4]

The time of day during which most farm accidents occur seems to confirm fatigue as a major factor, for there is a peak of incidence during late morning and another during the latter part of the afternoon. Both are times when there is normally a lowered blood sugar level and when the victim is beginning to tire from the work he has been doing for several hours.[8]

Accident-proneness is a factor, the importance of which is difficult to determine. The decision as to whether or not this factor has been of any importance in any one case, and if so, the determination of the degree of involvement, is necessarily a subjective one. Many difficulties are encountered in attempting to gather information relative to this factor. Most persons are rather hesistant in answering questions which relate to accident-proneness; in still other cases the accuracy of the reply is questionable.[9]

Weather is a factor in some instances. Extreme heat may increase the fatigue of work and in some cases may result in dizziness and loss of emotional balance. Cold weather requires the wearing of cumbersome clothing which catches easily on exposed machinery or barbed wire and often retards freedom of movement.[10] Snow and ice increases the hazards of the terrain, and rain may cause such a work delay that the farmer is forced to work even longer hours at an even greater rate of speed.

An impressive number of accidents involve a "third party," a person other than the victim who is directly involved in the accident but is seldom injured himself. This is probably due to the complex nature of many farm activities, such as baling and combining, which require more than one person for their proper execution. Thus one person may be distracted by the other, catching his hand in a machine or cutting his finger with the rotary saw he is using. In some cases the victim is injured through no fault of his own, but because a third party pushed the wrong button, pulled the wrong lever, or turned on the power at the wrong time.

Use of alcoholic beverages plays a part in some accidents but here, as in accident-proneness, it is a difficult factor to evaluate because of the natural reticence of the victim and his family.

The physical limitations of the victim are of great importance in some cases. The partially deaf individual, the man with an uncorrected visual defect, or the person with an amputated arm is working under a true handicap. A good example of this is the 60-year-old farmer with arthritis who fell from a tree into which he had climbed in order to fix a pulley which he had previously hung from one of its upper limbs.

These are but a few of the factors which may be of importance in the etiology of farm accidents. It must be remembered that each case is an entity in itself and has its own peculiar factors of causation, some similar to those of other cases, but others which are unique to that accident and of vital importance in the causation of that accident only.

We must emphasize that the above impressions and conclusions are the result of our experience with only 66 farm accident cases and a review of other similar surveys cited above. Furthermore, to our knowledge, there has been no study made of the habits, actions, and routine of the average farmer and as a result there is at present no norm with which comparisons can be made.

ROLE OF THE PHYSICIAN

The physician in rural practice who treats farm accident victims and who renders medical care to their families is in a key position to play a role in prevention. The most important aspect is in education. Availability of literature on farm safety in the waiting room; discussion with the farmer of safety problems on his own farm, especially the need to protect his children; and encouragement for the farmer to take courses in farm safety are a few ways this can be done. Specific measures for prevention include a search for physical defects, especially of sight or hearing, that might lead to accidents; their correction; and recommendations for limitations of activities beyond capabilities, especially in the older individual. Immunization against tetanus is a specific and necessary preventive measure for the farmer and all members of his family. All farm equipment should be in repair and all safety devices actually used.

These aspects are of a primary preventive level but early treatment, prophylactic administration of tetanus antitoxin where indicated, and immediate repair of any defective device related to the accident are also important. Since the farmer is self-employed, much emphasis should be placed on Blue Cross and Blue Shield insurance or some other form of health and accident protection. In the case of severe and disabling illnesses, the physician should be informed of social, welfare, and rehabilitative services in his community, especially the services of the State Vocational Rehabilitation program.

SUMMARY

1. A study of 66 farm accidents requiring medical care occurring in Dane County, Wisconsin, in the summer of 1956 has been made by means of personal interview, standard questionnaire, and on-the-spot visits. The results of these studies have been compared with those of others reported in the literature.

2. Machines, falls, and animals account for the majority of accidents and often result from unfamiliarity with the object, poor state of repair, and carelessness.

3. In most accidents, human factors outweighed the mechanical. Children and the aged (60 to 69) constituted special risks. Fatigue, working after hours, and hurrying were common in accidents. Medical disability was infrequently associated.

4. The most common injuries were fractures, lacerations, contusions and abrasions in that order. Hospitalization was necessary for only 13 of the 66 (20%), but was expensive since an average hospital stay of 14 days was involved. In all 66 cases, a total of 1,391 days of partial disability resulted, an average of 21 days per accident. Approximately half the victims had total insurance coverage, and 19 others were partially covered.

5. Few of the accident victims had taken formal training in farm safety.

6. The role of the rural physician in prevention of farm accidents and in minimizing their consequences is discussed.

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DOCTOR'S ROLE IN ADOPTIONS

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Cutaneous Necrosis Due to Norepinephrine: Analysis of Reported Cases and Surgical Treatment*

By A. STEPHEN CLOSE, M. D., and WILLIAM H. FRACKELTON, M. D., F. A. C. S.

SINCE Tullar[1] isolated norepinephrine (Levophed) in 1948, it has received steadily increasing use in various hypotensive states. Many reports of local ischemic complications following its intravenous administration have appeared in the past five years and those reported probably represent but a small fraction of the total number that have occurred. The treatment of these sloughs has received little attention in the literature pertaining to this subject. Our interest in this problem has led to a laboratory investigation of the mechanisms and possible prevention of such local complications; this will be the subject of a subsequent report.[2] The present report is an analysis of the clinical features of the cases thus far documented. To this review are added 6 cases of our own, with emphasis on the surgical treatment of the resulting slough. A preliminary report of a method for preventing sloughs will be outlined.

CLINICAL ASPECTS

Norepinephrine is a potent vasopressor agent. It is the specific active substance released at adrenergic nerve ending.[3-5] The clinical indications for its use have included the hypotension associated with myocardial infarction, toxemia, sepsis, surgical removal of pheochromocytomas and sympathetic chains, and overdosage of adrenolytic agents.

Since 1951 when Deterling and Apgar reported an instance of necrosis of skin overlying an area of extravasation of norepinephrine near the ankle, an additional 54 instances of slough occurring in 45 patients have been described. Twelve of these cases of four authors[6-9] are not reported in sufficient detail to provide a basis for analysis or comparison. The others are summarized in table 1, with our 6 cases. Also included are two cases of slough following continuous intravenous phenylephrine (Neosynephrine).

Only 8 of the 51 tabulated instances of slough occurred in the upper extremity. In the three instances of administration by ordinary needle in an antecubital vein, definite extravasation was noted in two. No extravasation was noted in the five instances of plastic catheter administration in the arm. Forty-three of the 51 cases of slough followed administration of norepinephrine in lower extremity veins. Extravasation was noted in each of the six instances of administration by ordinary needle into ankle veins.

Although the duration of infusion ranged from one to 96 hours, 80% of the sloughs occurred after at least 12 hours of continuous infusion. The norepinephrine concentration ranged from 2 to 160 mg. per liter.

ETIOLOGY

It seems apparent that prolonged and severe vasospasm with resulting cellular anoxia causes the necrosis. The diminished peripheral flow associated with early hemorrhagic or traumatic shock has been shown by Chambers and Zweifach[10] to occur with a "hyperreactive" phase of vasomotor tone in the arterioles, metarterioles, and precapillary sphincters. During this phase increased sensitivity to vasopressors occurs. The duration of exposure to norepinephrine is also important, but the concentration of the drug is probably not a greatly significant factor.

Bifulco believes that slower flow in the vessels of the lower limbs is responsible for the greater incidence of slough in the leg. How slough occurs when extravasation has been prevented by tying the vein around a plastic catheter has not been established. Several factors have been assigned variable etiologic importance by some authors.[6,11-14] These include: (1) Inadequate dilution of the drug due to a decrease in blood flow secondary to ligation of the "infusion" vein; (2) Spasm of the infusion vein with backflow via the tributary veins into the capillary bed and

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Author	Cause of Hypotension	Age of Patient	Type of Infusion	Site of Infusion	Extravasation	Concentration of Drug	Duration of Infusion	PVD*	Result
Bergman[11,19]	Cardiac arrest	54	Plastic catheter	Right ankle, great saphenous	No	100 mg./l.	60 hrs.	?	Slough along vein
	Postoperative enteritis with shock	50	Plastic catheter	Small lower leg vein	No	30 mg./l.	Total of 8 days	?	Slough
			Plastic catheter	Small lower leg vein	No	30 mg./l.			Slough
			Plastic catheter	Small arm vein	No	30 mg./l.			Slough
			Plastic catheter	Small arm vein	No	30 mg./l.			Slough
	Hemorrhagic shock	49	Plastic catheter	Dorsum of foot	No	160 mg./l.	18 hrs.	?	Slough above catheter
Byrne[20]	?	?	Plastic catheter	Antecubital vein	No	?	?	?	Slough along vein from catheter tip up
Crawford and Haynes[12]	Acute pancreatitis	30	?	Right femoral vein	?	4 mg./l.	6 hrs.	?	Slough at site of infusion
	Postoperative gastrectomy—abscess	57	Plastic catheter —25 cm.	Ankle, great saphenous	No	?	?	?	Slough from ankle to knee
	Postoperative—TUR—shock	52	?	Antecubital vein	?	4 mg./l.	24 hrs.	?	Slough at injection site
Deterling and Apgar[15]	Postoperative sympathectomy	?	?	Ankle, great saphenous	Yes	?	"Prolonged"	?	Slough in area of extravasation
Frazier[21]	Diarrhea and shock	?	Needle	Antecubital vein	Yes	?	?	?	Slough in area of extravasation
Greenwald, *et al.*[22]	Myocardial infarction	56	Needle	Ankle, great saphenous	Yes	16 mg./l.	?	?	Slough along vein and extravasation
	Cardiac failure	?	Needle	Ankle, great saphenous	Yes	16 mg./l.	?	?	Slough in area of extravasation
Hardie and Hunter[16]	Postoperative pulmonary lobectomy	41	Plastic catheter	Ankle, great saphenous	No	8 mg./l.	12 hrs.	Varicose veins	Slough along vein
	Postoperative mesenteric thrombosis	55	Plastic catheter	Ankle, great saphenous	No	2–4 mg./l.	48 hrs.	None	Impending slough, lower legs – died
			Plastic catheter	Ankle, great saphenous	No	2–4 mg./l.	?		Sup. phlebitis, then impending slough–died
	Cerebrovascular accident	73	?	Ankle, great saphenous	?	8 mg./l.	72 hrs.	None	Slough, medial lower leg
			?	Ankle, great saphenous	?	8 mg./l.	72 hrs.		Slough, medial lower leg
	Myocardial infarction	55	?	Left leg	?	4 mg./l.	96 hrs.	None	Slough, medial lower leg
	Heat prostration	70	?	Right ankle	?	4 mg./l.	72 hrs.	None	Slough, medial lower leg
Humphreys, *et al.*[13]	Postoperative shock	18	Canula	Left ankle, great saphenous	No	?	1 hr.	?	Slough at ankle
			Canula	Right ankle, great saphenous	No	?	"Brief"		Slough at ankle
	Postoperative shock	63	?	Left ankle	No	?	"Prolonged"	?	Slough
			Canula	Right wrist	No	?	26 hrs.		Slough
	Postoperative urethral dilatation	49	Canula	Right ankle, great saphenous	No	?	46 hrs.	?	Long narrow slough along vein
Irvin and Bunch[23]	Perforation of esophagus	55	Plastic catheter	Ankle, great saphenous	No	?	?	?	Slough along vein from tip of catheter
	Perforation of esophagus	66	Plastic catheter	Ankle, great saphenous	No	?	?	?	Slough along vein from tip of catheter
Kepes, *et al.*[13]	Postoperative mitral heart disease	26	Horsely canula	Ankle, great saphenous	No	4 mg./l.	48 hrs.	?	Slough along vein from tip of catheter. Microscopic: no venous thrombosis
	Postoperative hemorrhage	75	Horsely canula	Ankle, great saphenous	No	4 mg./l.	6 hrs.	?	Slough along vein from tip of catheter. Microscopic: no venous thrombosis
	Bacteremia	66	Plastic catheter	Ankle, great saphenous	No	4 mg./l.	24 hrs. +	?	Slough along vein from tip of catheter. Microscopic: no venous thrombosis

Author	Cause of Hypotension	Age of Patient	Type of Infusion	Site of Infusion	Extravasation	Concentration of Drug	Duration of Infusion	PVD*	Result
Kurland and Malach[24]	Cholangitis—sepsis	73	Plastic catheter	Ankle, great saphenous	No	4 mg./l.	?	?	Slough along vein from tip of catheter
Pierce and Polley[25]	Postoperative malignant hypertension	52	Plastic catheter	Ankle, great saphenous	Yes	Neosynephrine 20 mg./l.	?	?	Slough in area of extravasation
	Postoperative mitral stenosis	39	Needle	Ankle, great saphenous	Yes	Neosynephrine 20 mg./l.	?	?	Slough in area of extravasation
Uricchio, *et al.*[17]	Postoperative mesenteric infarction	48	Canula	Ankle, great saphenous	No	?	2 hrs.	Severe arteriosclerosis obliterans	Slough along vein to above mid thigh—amputation
Wall and Hanlon[26]	Myocardial infarction	52	Plastic catheter	Right ankle, great saphenous	Yes	4 mg./l.	14 hrs.	?	Slough at and above malleolus
	Endometritis—septicemia	29	Canula	Right ankle, great saphenous	No	8 mg./l.	26 hrs.	?	Slough above ankle
			Needle	Right antecubital vein	Yes	8 mg./l.	?	?	Slough at needle site
	Postoperative shock	68	Canula	Right ankle, great saphenous	No	8 mg./l.	20 hrs.	?	Slough along vein above ankle
	Postoperative enteric fistula	29	Canula	Left ankle. great saphenous	Yes	8 mg./l.	12 hrs. +	?	Slough on dorsum of foot and ankle
	Postoperative mastoidectomy	54	Plastic catheter	Right ankle, great saphenous	?	24 mg./l.	2–4 hrs.	?	Slough above catheter
			Plastic catheter	Left ankle, great saphenous	No	2–4 mg./l.	15 hrs.	?	Areas above catheter crusted and healed spontaneously
	Head injury—comatose	27	Plastic catheter	Right ankle, great saphenous	Yes	48 mg./l.	9 hrs.	?	Slough above catheter
			Plastic catheter	Left knee, great saphenous	?	48 mg./l.	?		Impending slough at catheter tip—died
	Postoperative lysis of adhesions	87	Plastic catheter	Right ankle, great saphenous	Yes	8–16 mg./l.	30 hrs.	?	Slough above catheter. Microscopic: extensive thrombosis of all vessels
Close and Frackelton	Postoperative colon resection—enteritis	59	Needle	Right ankle, great saphenous	Yes	16 mg./l.	24 hrs.	None	Slough in area of extravasation
	Pyelonephritis—bronchopneumonia	82	Needle	Right antecuhital vein	No	8 mg./l.	16 hrs.	None	Slough at needle site
	Postoperative TUR spinal—hemorrhage	59	Plastic catheter	Right ankle, great saphenous	No	8 mg./l.	22 hrs.	None	Slough extending up from incision
	Myocardial infarction	55	Plastic catheter	Left ankle, great saphenous	No	4 mg./l.	24 hrs.	Varicose veins and moderate arteriosclerosis obliterans	Slough along vein from tip of catheter
	Postoperative enterocolitis	67	Needle	Left ankle, great saphenous	Yes	2 mg./l.	2 hrs.	None	Slough in area of extravasation
	Postoperative bowel fistula	63	Plastic catheter	Left thigh, great saphenous	No	2 mg./l.	14 hrs.	None	Large slough above catheter tip

*PVD—Peripheral Vascular Disease

Fig. 1—Appearance of slough 96 hours after extravasation of Levophed in thigh.

Fig. 2—Same area three weeks after split thickness skin graft.

arterioles due to the hydrostatic pressure of the infusion; and (3) Ischemia of the vein wall resulting in its increased permeability and diffusion of the drug into the adjacent tissues. Only one writer[15] suggests proximal thrombosis of the infusion vein as a causal factor. Observations made in our laboratory[2] support the theory that spasm of the infusion vein (with concurrent spasm of the vasa vasorum) leads to diffusion through the vein wall. Additional evidence for this concept is the fact that in many of the published illustrations and in our own cases the necrosis extended proximally along the vein from the tip of the catheter rather than from the site of entry of the catheter. In several clinical instances a narrow zone of ischemia has been noted along the course of the saphenous vein from a catheter tip at the ankle all the way up to the groin.

PREVENTION

It is important to prevent extravasation by securing canulas or catheters by ligature, and it has been recommended by many that only this method of administration be used. It is also generally agreed that the muscular part of the arm should receive preference as the site of administration, and Bergman, and Crawford and Haynes think the catheter should be passed up into a large vein, *i.e.*, the iliac, subclavian, or vena cava. Obviously, giving the drug in an extremity involved by peripheral vascular disease is to be avoided.

Ischemic areas which will frequently progress to necrosis have a typical appearance. They are very cold, pale, and, if associated with localized extravasation, are boggy. They

are frequently tender, and usually the patient complains of pain before they have been present very long, sometimes even before there is any obvious ischemia.

Solutions containing hyaluronidase, hyaluronidase and procaine, and hyaluronidase and papaverine have been recommended and used, but apparently without notable success.[13, 16, 17] If these ischemic areas are infiltrated with 2.5 to 5.0 mg. of phentolamine methane sulfonate (Regitine) and 300 TRU of hyaluronidase in 10 to 30 cc. of normal saline (amount of drug and diluent are determined by size of area involved) before irreversible changes have occurred, a very prompt and dramatic improvement will be noted. Since the action of norepinephrine on effector cells within the infiltrated area will be blocked for at least two to three hours, the norepinephrine infusion can be continued for such a period without danger. This dose of Regitine has produced no significant systemic effect when given subcutaneously to an adult. Recently, McGinn and Schluger[18] have also developed a method of prevention using Regitine and have used it with success in four clinical cases. The extremity in which the infusion is being given should be inspected at frequent intervals, since the ischemia must be ablated before irreversible changes ensue. If areas of ischemia continue to develop and prolonged norepinephrine administration is necessary, a plastic catheter should be passed into an iliac vein through a high saphenous phlebostomy. Development of areas of ischemia have not been noted with this technique.

TREATMENT

Since the majority of the patients who receive norepinephrine are critically ill, it is wise to delay surgical treatment of the slough until the patient is out of danger. A thick, tough, black eschar (fig. 1) usually forms in the area of necrosis and involves all layers of skin. This eschar should be protected with a simple dry gauze dressing and immobilization if the area is near a joint. The eschar remains impervious for two to four weeks, a period sufficient to permit enough improvement in the patient's general condition to warrant definitive treatment of the slough. The eschar is then removed at the bedside by sharp dissection. Anesthesia has not been necessary for this debridement in any instance. After several days of intermittent moist saline dressings, a thin split thickness skin graft is removed and applied to the granulation bed under local anesthesia.

SUMMARY

Sixty-one instances of cutaneous necrosis due to norepinephrine have been collected and tabulated. It is concluded that slough is more likely to occur in the lower extremity after prolonged administration, and where extravasation is permitted.

Two effective methods for preventing slough are presented:

1. The infiltration of ischemic areas with a saline solution of Regitine and hyaluronidase.
2. Administration of the norepinephrine through a catheter in the iliac vein via a high saphenous phlebostomy.

A conservative policy of delay in the surgical treatment of the established slough is presented.

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Clinicopathologic Conference

Sponsored by the Section on Pathology, State Medical Society of Wisconsin
Guest Editor: David J. Carlson, M.D.

PROTOCOL

This 74-year-old white female was admitted because of a 20-pound weight loss within the past 3 to 4 months. This was accompanied by easy fatigability and weakness. The patient had had a poor appetite for many years. She denied nausea, vomiting, and abdominal pain. Bowel movements were usually regular. However, the patient did have occasional loose stools after eating related by her to what she had eaten. At no time was the stool black or bloody. She had had a thyroidectomy about 12 years ago.

Physical examination revealed an elderly white female in no acute distress. No abnormalities of the head and neck were noted. Blood pressure was 180/124 mm. Hg.; pulse was 78. The heart was enlarged. The point of maximal impulse was felt at the midclavicular line. A systolic murmur was heard over the aortic and mitral areas. The lungs were clear to percussion and auscultation. The breasts were negative. The abdomen was soft and non-tender. The liver edge was palpable about 2 finger breadths below the costal margin. Bowel sounds were very active on the right. There was an eczematoid scaly lesion on the posterior aspect of the right leg.

Laboratory data on admission included a hemoglobin of 2.3 gm. with a 40 hematocrit. White blood cell count was 5,350. Sedimentation rate was 5 mm. in one hour. Prothrombin time was 78%, total protein 6.15 gm. Preadmission and admission x-ray studies revealed sclerosis of the aorta with considerable left ventricular enlargement of the heart. The right leaf of the diaphragm was high. A barium enema showed diverticulosis of the left colon and sigmoid. There appeared to be a tumor in the terminal ileum, which intussuscepted into the cecum. The mucosa of the ileum at this point appeared destroyed, suggesting malignant tumor, for example lymphosarcoma. The patient was explored and a side-to-side ileocolostomy was done. The immediate postoperative course was good. Blood pressure ranged from 160/100 mm. Hg. to 180/120 mm. Hg. On the day following surgery the abdomen was soft and non-tender. There were normal bowel sounds. The patient was up at the bedside but drowsy. On the second postoperative day, the patient was described as "lethargic and depressed." Slight icteric discoloration of sclerae was noted. On the next day the patient became unresponsive. Marked cyanosis developed about the nose and mouth and over the lower extremities. The skin of the extremities was cold. Blood pressure was 160/80 mm. Hg.; pulse was 120. Respirations were 28 per minute. The abdomen was soft; peristalsis was present. Four hours later the patient had responded well and she was talking to relatives. Treatment given included oxygen and one unit of whole blood. There was one yellow-green liquid stool on this day.

On the fourth postoperative day the jaundice was deeper. Serum bilirubin was 14.78 mg.% with 9.0 mg.% direct and 5.78 mg.% indirect. The patient again became lethargic with periods of confusion and "semi-coma." The abdomen continued to be soft. At 4:30 that afternoon nurses' notes revealed "diaphoresis and weak pulse." The hands and feet were cold; the trunk, however, was warm. Fingertips and nail beds were cyanotic. The cyanosis later spread over the face and extremities. The patient died at 6:30 p.m.

Dr. Albert G. Martin: This is a 74-year-old white female whose chief complaint was a 20-pound weight loss in 3 to 4 months accompanied by easy fatigability, weakness, and periodic episodes of loose stools after eating. Past history included thyroidectomy at age 62. On physical examination there was evidence of arteriosclerotic heart disease and hypertension with elevation of pulse pressure. The lower edge of the liver was palpated 4 cm. below the right costal margin. At this point we are not certain whether this is truly an enlarged liver. We do not know

where the upper edge of the liver may be. We hope the x-rays will be of some help in determining this. Bowel sounds were active. These findings are helpful and point toward an intra-abdominal lesion, probably intestinal with possible involvement of the liver.

The laboratory data supplies helpful information. There is no anemia, no evidence of infection. The prothrombin level is that usually seen in elderly individuals. The serum protein is not abnormal. All of these, of course, must be interpreted in the presence of weight loss. If dehydration was present, these levels are not as favorable as they seem. Erythrocyte sedimentation rate was 5 mm. in one hour. In the presence of possible malignancy, some people feel that this test has value. I personally do not feel that sedimentation rate is of significant help in the diagnosis of malignant lesions. X-rays were most helpful. They confirmed the diagnosis of cardiac enlargement plus calcification of the aorta. They also showed elevation of the right diaphragm. This last finding, coupled with the abdominal examination, confirmed the presence of an enlarged liver. Barium enema revealed an intussusception of the ileum, probably malignant. Because this is so obvious, I wonder whether it might have absolutely nothing to do with the problem in this case. May we see the x-rays, please?

Dr. J. L. Armbruster: A barium enema was done before upper intestinal tract evaluation. This enema showed a filling defect in the region of the ileocecal valve. There is x-ray evidence of minor intussusception of ileum into the cecum. This is very seldom seen in hypertrophy of the ileocecal valve, but is seen more frequently with tumor. The x-ray indicates, then, that there probably is a tumor involving the terminal ileum with intussusception of ileum into cecum.

Doctor Martin: For the house staff may I add that in a situation of this sort we should always follow the advice of the x-ray department, that is, do the barium enema before the upper gastrointestinal series. If barium be given by mouth in the presence of an obstructive lesion of the intestinal tract, acute intestinal obstruction may develop, a most serious complication. In this instance, barium was given by enema, and because of obstruction, no barium was given by mouth.

Now, for the preoperative summary. The surgeon apparently made a diagnosis of ileocecal intussusception and enlargement of the liver. It was believed to be tumor of the ileum with metastasis in an elderly woman who had a few other troubles such as diverticula of the sigmoid colon and arteriosclerosis.

I would like first to briefly discuss intussusception. Intussusception in adults is a different disease from that seen in children. In children intussusception occurs principally at the time when the child begins to eat solid foods. In 94% of cases there is no known cause, *i.e.* predisposing disease. In a few children there may be an underlying cause, such as Meckel's diverticulum, intramural tumor, or polyps.

There is another difference. In children, intussusception is a rapidly appearing tumor, producing intestinal obstruction and jeopardizing the blood supply of the intussusceptum very quickly. Early operative intervention is needed, unless the intussusception is reduced when barium enema is done. This latter procedure is not universally accepted by surgeons. Contrariwise in adults, intussusception occurs at any time, and definite etiology can almost always be demonstrated. Fifteen to twenty years ago it was thought that intussusception in adults was most often caused by benign lesions. Recently, however, there is an increasing number of reports linking malignant tumors with intussusception. In the January, 1956, issue of *Archives of Surgery,* Dean, Ellis, and Sauer[1] point out that as our population gets older and people live into the "cancer age," an increasing number of them will develop malignancy. Correspondingly, then, the number of adults with intussusception secondary to malignant tumor is also increasing.

The third difference betwen intussusception in adults and in children is in the clinical course. In adults intussusception, while it may present as an acute illness, is more often subacute or chronic. Emergency procedures are not always needed, and there is time for diagnostic workup. Also, in adults the benign lesions that predispose to intussusception are the same as in children, lesions such as Meckel's diverticulum, leiomyoma, adenoma, neurofibroma, angioma, plus

gallstones, and, interestingly enough, typhoid fever. The malignant causes of intussusception are generally three, all of which show increasing incidence in our population. In order of frequency they are lymphosarcoma, argentaffinoma or carcinoid, and adenocarcinoma. The most frequent physical finding is abdominal mass. This mass varies in size from the size of a cyst to that of a hen's egg. Size is something to remember. When you see a mass which varies in size, you must think of intussusception.

The operative note is an interesting one, and I hope Doctor Eberbach can tell us more of the details later. A side-to-side ileocolostomy was done. I suspect that this means that a tumor, most probably extensive and involving mesenteric structures, was present. Surgical philosophy in malignancy or tumor is usually excision. Certainly, excision of a localized lesion is not much more difficult than a short-circuit operation. I believe, however, that metastases were very likely present within the mesentery and, more important, within the liver. A "by-pass" operation under such circumstances would relieve obstruction, if present. It would prevent future obstruction and it would also decrease the likelihood of future intussusception.

The postoperative course was most puzzling. The patient died within 4 days. None of the complications for which the surgeon is always alert seem to have occurred here. There was no evidence of hemorrhage, infection, or intestinal obstruction. The course, rather, was one of drowsiness, and partial collapse. This collapse is a peculiar one. The patient was unresponsive and cyanotic about her face and legs. The skin of the extremities was cold. The blood pressure was 150/80. "Vascular" collapse of this sort is something with which a surgeon is not very familiar. It puzzles and distresses him greatly. Another curious thing about this episode was the prompt response to oxygen and blood. It does not appear that there was collapse due to peritonitis with peripheral vascular collapse and shock.

The postoperative course was marked, too, by very rapid development and progression of jaundice. Between the second and fourth day the bilirubin rose to 14.78 mg.%. The second episode of collapse resembled the first with semi-coma, facial cyanosis, high blood pressure, and peripheral vascular collapse.

There are several things which one must consider. What is the nature of the tumor in the ileum? I believe it is malignant. What is responsible for the enlarged liver? I believe it is metastatic tumor. And last, what was the cause of death with rapid development of jaundice, puzzling vascular phenomena, and constantly elevated blood pressure?

I would first like to inquire into the possible cause for jaundice. A serum bilirubin of 14.78 mg.% with 9 mg.% direct and 5.78 mg.% indirect would indicate biliary obstruction. The history in this case eliminates jaundice due to medication, hepatitis, or transfusion reaction. Jaundice can occur in a patient who has had intraperitoneal hemorrhage with absorption of blood. There is no evidence of hemorrhage in this case. Obstructive jaundice secondary to common duct stone, carcinoma of the extrahepatic bile ducts, colon, or pancreas can also be excluded. Besides, these conditions do not kill a patient so quickly.

In this patient the jaundice was associated with rapid death. We must consider some other cause for obstructive jaundice. Metastatic carcinoma would account for the large liver noted before operation. Metastatic malignancy also can produce both obstruction of the intrahepatic bile ducts with jaundice and rather rapid hepatic failure after anesthesia and operative ordeal. The clinical lethargy and coma could be explained by liver failure.

Next, I would like to inquire into the nature of the ileal lesion. I have indicated that I believe it was a malignant tumor. The likely possibilities are lymphosarcoma, carcinoid, and adenocarcinoma. Lymphosarcoma is a good choice. It occurs most frequently. It is particularly tempting to me because many of the patients whom I have seen with intussusception at the ileocecal area have had lymphosarcoma. Lymphosarcoma of the ileum can explain all of the phenomena which we have discussed except the terminal vascular collapse. These vascular phenomena were so prominent and responded so well to treatment that I wonder if one should not consider a hormone acting in concert with the ileal lesion. One immediately thinks of pheochromocytoma. Two weeks ago at the surgical conference we discussed such a case. The patient was a woman in her fifties who

had an emergency gastric resection because of hemorrhage. Jaundice developed after surgery, and the patient died approximately 8 days later. Jaundice was caused by an obstructive, chronic, fibrosing pancreatitis. Her life was jeopardized by an adrenal pheochromocytoma.

I am not prepared to make a diagnosis as exotic as that. While pheochromocytoma can manifest itself at all ages, it is most frequently found in the young adult in the twenties or thirties. The age of this woman is a factor in deciding against pheochromocytoma as a cause of death. Therefore, I have deleted lymphosarcoma with pheochromocytoma as a possible mechanism for death. We come next to adenocarcinoma. This can be ruled out for the same reason as lymphosarcoma. It meets the same objections when attempting to explain the terminal episodes.

Finally, there is the carcinoid tumor or argentaffinoma. In patients with metastases from argentaffinoma, bulky metastatic masses are produced. The tumors are resected with much difficulty, and in some instances resection is actually impossible. Recently, it has been shown that carcinoid is a hormone-producing tumor.[2] Moreover, this hormone, serotonin, is responsible for vascular phenomena,[3-8] etc., such as seen in this case. This makes us wonder whether the preoperative symptoms of loose stools and diarrhea might not have been on the basis of serotonin produced by carcinoid. I also wonder if there could be another factor such as portal vein thrombosis.

In conclusion, my diagnosis is carcinoid tumor of the ileum with mesenteric and hepatic metastases. The cause of death is liver failure due to biliary tract obstruction from metastases, and aggravated by portal vein thrombosis.

Dr. David J. Carlson: Do you or do you not wish to make the carcinoid in this instance a functional one?

Doctor Martin: Yes, I do.

Doctor Carlson: Do you wish to relate the preterminal and terminal episodes of cyanosis, etc., to the carcinoid?

Doctor Martin: Yes, I do.

Doctor Carlson: Doctor Eberbach, would you care to comment at this time as to what was seen at surgery and perhaps answer some of the questions Doctor Martin has asked, specifically the surgical philosophy employed. I suspect that this will be very much in accord with what he has said.

Doctor C. W. Eberbach: The lesion found at operation was considered an inoperable one. At the time of surgery it was not appreciated that this was a carcinoid or argentaffinoma. There were extensive hepatic metastases. The "by-pass" procedure of side-to-side ileotransverse colostomy was done, primarily as a palliative procedure, to obviate obstruction and future intussusception.

Dr. Lamont Schweiger: I would like to compliment Doctor Martin on his presentation, and concur in his diagnosis of functioning malignant argentaffinoma with metastases. The first association of carcinoid tumors with valvular abnormalities was established by Thorson. More recent studies have described the relationship of the valvular abnormalities of the right side of the heart with a hormone, 5 hydroxytryptamine or serotonin, produced in the tumor.

The variation in the results of physical and x-ray examinations and the comments concerning the cardiac diagnosis deserve a statement. The protocol reveals the presence of cardiac enlargement with the maximum cardiac impulse at the midclavicular line. This, of course, is inconsistent since the midclavicular line commonly demarcates the transition between grossly normal and grossly abnormal heart size. X-ray examination disclosed striking enlargement of the heart with the left ventricular border nearly at the anterior axillary line. These clinical inconsistencies point out that we often do not obtain the maximum benefit from physical examination. For example, percussion of the heart borders, while not an exact procedure, permits one frequently to establish gross heart size. Furthermore, with this much cardiac enlargement, the character and size of the maximum cardiac impulse could be expected to provide very important information concerning the mass and state of the left ventricle. Reference is made in the protocol to the presence of a systolic murmur over the aortic and mitral areas. Here again, the features of murmurs which help significantly in their evaluation are not utilized. The area

of maximum intensity, the position of the murmur in the cardiac cycle, the intensity of the murmur, its duration and direction of transmission all are of great importance. It is not uncommon for a murmur arising at the aortic valve to be heard more clearly at the apex. Further, the diagnosis of arteriosclerotic heart disease on the basis of the patient's age and cardiac enlargement is untenable. There is nothing in the protocol to permit this diagnosis, since the patient did not experience angina pectoris or myocardial infarction. An electrocardiogram was not obtained, so this opportunity to establish electrical evidence of old infarction was not available. It would seem much more plausible to relate the cardiac enlargement to arterial hypertension, to a valvular defect, or both.

Dr. C. W. Wolfe: The description of the cyanosis in this case appears to correspond closely to what is written concerning cyanosis in this syndrome. It has a peculiar distribution, as opposed to that usually seen, being patchy, preceded by flushing, and not associated with shock.

Doctor Carlson: It is evident that everyone here is aware that the cyanosis in this case is related to a metastasizing carcinoid. The distribution was its most characteristic feature. Description in the protocol of the first episode was taken from notes of the house staff, that of the second episode from observations by the nurses. Peculiarly, the chest was warm and pink, but the extremities were cold and cyanotic. The nurses' notes also indicate the extreme cyanosis of the face and state that it was "patchy" but "spreading over the entire face."

At autopsy there was tumor, a carcinoid of the ileum. It was a circinate, hard, infiltrating mass approximately 2 cm. in diameter and located about 1 cm. proximal to the ileocecal valve. The tumor was yellow-gray. It penetrated the entire wall of the ileum. The adjacent mesentery was studded and indurated by tumor that converted the mesentery into a firm, rigid, thickened mass. The ileocecal valve was edematous and hemorrhagic, related most likely to previous intussusception. The ileocolostomy had been competently done; suture lines were intact.

The liver weighed 2,180 gm. It was massively invaded by metastatic tumor. The individual masses varied from 0.5 cm. to 8.0 cm. in diameter. They varied in consistency from firm, rubbery, and gritty to soft, mushy, and cystic. In the former instance, the masses were yellow and gray. In the latter they were red, hemorrhagic, and tan.

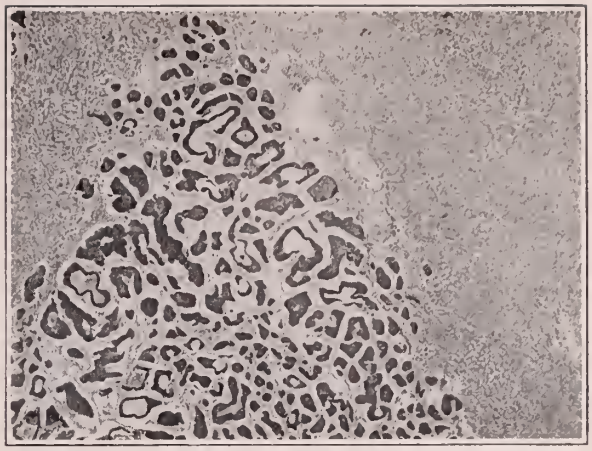

Fig. 1—Metastatic argentaffinoma within liver.

Microscopically, the primary and secondary tumor masses were comparable. Small to large solid nests of small cells were seen embedded within a fibrous stroma. In most areas the tumor was very cellular. The cells had deeply stained, round to oval nuclei. Cytoplasm was moderate. Special stains revealed fine granules within the cytoplasm.

The heart afforded the next most important finding. It weighed 540 gm. with definite enlargement and hypertrophy of the right ventricle. The pulmonic valve was stenotic. The cusps were unusually thick and rigid. Free margins were curled. The endothelial surfaces, however, were smooth and no vegetations were found. The leaflets were fused, with loss of commisural outline. The tricuspid valve showed similar but less profound thickening. There was fibrous thickening of the endocardium within the right auricle and ventricle.

Microscopically, the pulmonic valve leaflet was very short and thick. Deeper portions consisted of dense, acellular, hyalinized tissue. Near the surface the tissue was loose and edematous. When this was first seen by us, we were convinced that it was not congenital, rheumatic, arteriosclerotic, or inflammatory. We felt that it might be related to aging, but were unhappy with that diagnosis. Since this patient died, changes such as this have been seen by others. The endocardial surfaces of the right heart were also thickened and fibrous.

Relative to carcinoids of the ileocecal area, there are three problems. First, the symptomatology because of tumor is peculiar and characteristic. That has been covered by Doctor Martin. Secondly, the biology of the tumor affects the basic philosophy of surgical management. And finally, since Thorson's article, the vascular and pulmonary phenomena have become increasingly important.

In recent years, argentiffinomas, wherever they occur, have come to be considered malignant, albeit slowly growing, tumors.[4,9,10] They pursue, if patients live long enough, an inexorable and persistent course. Metastases to the mesentery and, in turn, the liver will develop. When these tumors grow within the ileocecal area, they produce, as this tumor did, obstruction and intussusception. If seen when small or only locally infiltrating, carcinoids of the ileum can be resected. In fact, they should be resected, even in the presence of few or isolated metastases to the liver. The latter, according to some,[4,11] should be removed whenever possible. Growth is slow and metastasis delayed so that long-term survival is many times possible following local excision.

The last problem concerning carcinoid is functional. When the autopsy was done, we, too, were puzzled by the terminal vascular phenomena and valvular disease. Initially, we did not associate tumor with cardiac disease. In fact, autopsy antedates most of the articles that report this association. However, review of recent articles, the autopsy, and the clinical course in this patient removes all doubts in our minds that this was a functioning argentaffinoma. We do not have serotonin, or 5 hydroxy-indole-acetic acid determinations. We do not in this case because we were not doing them at that time. We are, however, doing urinary 5 HIAA determinations now, but have not found a positive test. This patient apparently represents "lost opportunity."

Pathogenesis of valvular disease has not been found. Localization to the right heart appears related to the fact that serotonin is converted to 5 HIAA within the lung. The latter is an inert, inactive substance excreted in urine. The right heart is therefore "bombarded" with serotonin in contrast to the left heart. The late appearance of symptoms due to valvular and cardiac disease appears related to metastatic tumor. Significant amounts of serotonin reach the heart only

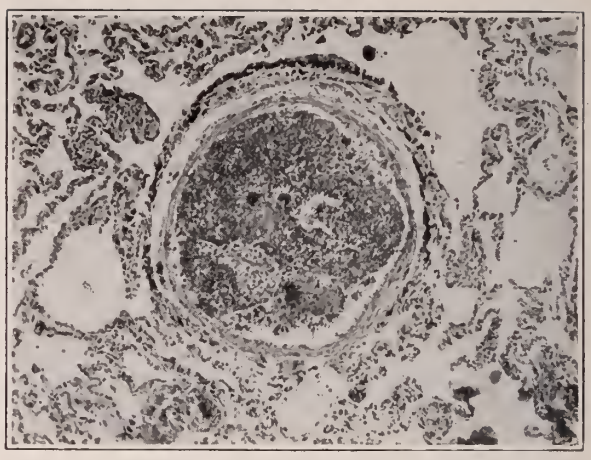

Fig. 2—Lung, intravascular thrombus.

after metastasis produces a great volume of functioning tissue or tumor. Serotonin has also been found within platelets as a "clotting factor."[12] Possible explanation for valvular thickening may lie in focal thrombosis of small veins at the base of the valve with gradual organization and fibrosis of the cusp. Another factor may lie in pulmonary vasodilatation and constriction with pulmonary stasis followed by dilatation and eventual hypertrophy of the right heart. In this case, we also found thrombi and emboli within several small and medium-sized vessels of the lung, an observation reported by others.[13]

The diarrhea, "flushing," cyanosis, and "eczematoid" lesions of skin are related to vasomotor effects of serotonin. Careful review of hospital stay and past history indicates that this patient had had the intestinal, dermal, and vascular manifestations of serotonin activity for several years.

The diagnoses in this case are: 1. Malignant carcinoid or argentaffinoma of ileum with metastases locally to mesentery and distally to liver; 2. Pulmonary stenosis, tricuspid regurgitation, and subendocardial fibrosis of the right heart secondary to functioning argentaffinoma; and 3. Hepatic failure secondary to massive tumor metastases with obstructive jaundice.

Doctor Martin: I am interested in the hepatic disease and metastases. I wonder how much help the laboratory could be in discerning whether tumors have metastasized to the liver. Could one find out if jaundice is related to hepatic metastases? Are there any laboratory tests which might help in determining the extent or severity of such metastases?

Dr. E. A. Birge: Laboratory tests recorded here do not give much help. In fact, the laboratory is not very helpful in diagnosing the presence or absence of metastatic tumor within the liver. I believe, however, that in the presence of significant metastases, serum alkaline phosphatase and serum transaminase determinations could be of assistance in evaluating presence of metastases and character of jaundice.

Doctor Martin: Was there any evidence of portal vein thrombosis?

Doctor Carlson: None was noted specifically. I will say this, however, that while no reference to portal vein thrombosis appears in the autopsy protocol, it most probably was not found. Portal vein thrombosis is so unusual and rare that, whenever present, it cannot really be missed.

If there is no more discussion, it is time to adjourn. Before we do, I must compliment several members of the house staff in submitting the correct diagnosis in this case. That indicates to me that our house staff is aware of current medical literature; and more important, they are reading it.

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WISCONSIN ASSOCIATION OF BLOOD BANKS

Annual Meeting, May 3, 1958, Milwaukee, Wisconsin

A.M.

9:00 Registration—Ambassador Hotel, 2308 West Wisconsin Avenue

9:30—11:30 Open House—Milwaukee Blood Center, 763 North 18th Street

P.M.

12:15 Luncheon—Ambassador Hotel

Mr. Robert Suerth: Wisconsin Rapids: *"Progress in Accreditation on Blood Banks in Wisconsin"*

2:00–2:30 Marie Koch, M.D., Wood, Wisconsin: *"Bacteriologic Problems in Blood Banking"*

2:30–3:00 E. S. Olson, M.D., Racine: *"Evolution of the Procedures Used in an Attempt to Reduce Hepatitis in Blood Banking"*

Ned G. Maxwell, M.D., Milwaukee: *"Results of Screening by Laboratory Tests for Silent Hepatitis Carriers"*

3:00–3:30 Joseph D. Boggs, M.D., Chicago: *"Special Blood Bank Preparations and Their Clinical Use"*

3:30–4:15 Fred Madison, M.D., Milwaukee: *"The Use and Abuse of Blood"*

6:30 Dinner and Business Meeting—Ambassador Hotel

Entertainment: Robert Neller, Ventriloquist

Luncheon $1.85; Dinner $3.75. Reservations to Mr. James Fosshage, P. O. Box 603, Madison 1, Wis.

Water Pollution Control Grants

As It Looks to Your State Board of Health

THE Federal Water Pollution Control Act, Public Law 660, provides for grants to states to assist them in meeting the cost of establishing and maintaining adequate measures for the prevention and control of water pollution. Allocations to states are based on the extent of the pollution control problem, the financial needs of the respective states, and their population.

A state water pollution control plan providing for administration, reporting, extension and improvement of the program, and the accounting and budgeting essential to the proper and efficient administration of water pollution control has been developed by the state and approved by the Surgeon General of the Public Health Service. Activities under the plan have been fitted into the activities financed by appropriations made available by the Wisconsin Legislature. Under a research contract with the University of Wisconsin, a study is being made of the effect of pollutants on the flavor of fish in certain of our streams. It is hoped that this study will eventually lead to the determination of specific compounds which cause off-flavors in fish so that proper remedial action can be taken.

The Federal Water Pollution Control act provides for grants-in-aid to municipalities for construction of treatment works. Under this section, "treatment works" is defined to mean the various devices used in the treatment of sewage and industrial wastes of a liquid nature, including the necessary intercepting sewers, outfall sewers, pumping power, and other equipment, and their appurtenances, and includes any extensions, improvements, remodeling additions, and alterations thereof.

The act provides for a ten-year grant-in-aid program to provide $50,000,000 per year for construction grant-in-aid. During the fiscal year ending June 30, 1957, a total of $971,725 was allocated for distribution to Wisconsin communities on the basis of water pollution control need and financial need. In the first year of the program, 55 communities made application for Federal grant-in-aid, requesting grants in excess of three million dollars. As grants could not be provided for all applicants, a system of priorities was established, and the first allotment provided grants for 14 communities. All of these municipalities have plants under construction.

For the fiscal year ending June 30, 1958, the allotment for Wisconsin communities amounted to $974,625. This time there were 59 applications on file with requests for grants again amounting to over three million dollars. The projects of 21 municipalities were certified for priority this year. It is expected that all of these municipalities will proceed with construction during 1958.

In order that work would proceed promptly after allocation of grant priority, first consideration was given to municipal sewage treatment construction and improvement projects for which plans had been submitted or were already approved. This action resulted in placing under construction at one time a large number of projects in the first year, and is making it possible for communities this year to set early bid dates with the purpose of commencing construction in spring.—THEODORE F. WISNIEWSKI, *Director, Committee on Water Pollution.*

JACKSON FOUNDATION MEETING

The two postgraduate meetings sponsored by the Jackson Clinic and Foundation have been scheduled for Thursday, April 17, and Thursday, May 29. The topic will be "Recent Advances in Diagnosis and Treatment." Each meeting will feature a question and answer panel with the title "The Most Difficult Problems Encountered in Practice." A senior staff member will make a special presentation at each meeting.

DIABETIC SUMMER CAMP

Boys and girls from eight through fourteen years of age are eligible to attend the summer camp for diabetic children at Holiday Home, Lake Geneva, Wisconsin, from July 20 through August 10. The camp is sponsored by the Chicago Diabetes Association, 5 South Wabash Avenue, Chicago 3. Inquiries are invited.

The camp will be staffed by resident physicians, a nurse, two dietitians and a laboratory technician, in addition to regular counseling staff.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee
F. E. SHIDEMAN, M. D., University of Wisconsin, Madison

Timing the Oral Penicillin Dose

The area "down under," *i.e*, Australia, has been surprising and delighting us in recent years with a series of fine contributions in the biological sciences and particularly with penetrating analyses in clinical medicine. I offer here a sketch of the observations of E. R. H. Clarke and associates[1] of Melbourne regarding the effect of food on absorption of penicillin given by mouth. According to these investigators, previous recommendations that penicillin should be given before meals or midway between meals have been unsupported by satisfactory evidence. They studied the effect on the duration of therapeutic serum concentrations of penicillin when it was given at seven different times relative to breakfast to the same 10 subjects. Contrary to previous suppositions, penicillin persisted longest in the blood if the dose was given with meals. The experiments were designed to test duration of effect, no attempt being made to detect the height or time of peak serum concentrations. Some evidence suggested that absorption of penicillin was slower when the antibiotic was given orally with breakfast (and slow absorption probably indicates lower peak concentration) but more uniform results, from the standpoint of duration of therapeutic titers in the blood, were obtained when penicillin was given with a meal than when it was given before. The next longest persistence times were observed when the dose was given one-half to one hour before or one hour after breakfast. The shortest persistence times were observed after doses given two, three, or four hours after breakfast. Penicillin given with or one hour after lunch resulted in longer persistence times than the same dose given one hour before lunch (three hours after breakfast). Recovery of penicillin in the urine was usually greatest when the agent was given before breakfast, less when given with breakfast, and least when given after breakfast. It could be detected in the blood almost as promptly after a dose given with breakfast as after a dose given on an empty stomach.

These findings of Clarke's group would seem to negate the frequently reiterated admonition to give oral penicillin between meals rather than when the stomach is full or food is being taken. Actually they do not, however, for the concern of most investigators heretofore has been with the height of the penicillin titer reached rather than with the duration of the minimal effective titer. The latter would certainly seem often to be the more important, and it will therefore be interesting to see whether the present investigators' observations regarding the relationship of food to absorption can be independently confirmed.—HARRY BECKMAN, M. D.

REFERENCE

Clarke, E. R., et al.: The effect of food on the absorption of penicillin given by mouth, M. J. Australia 1:61–67 (Jan. 19) 1957.

MEDICAL MOTION PICTURES

The ninth annual publication of "Reviews of Medical Motion Pictures" is now available on request from the Film Library of the American Medical Association, 535 North Dearborn St., Chicago 10. This publication contains reprints of all film reviews published in the Journal of the A.M.A. during 1957. It is prepared by the Council on Scientific Assembly, Motion Pictures and Medical Television.

WORLD HEALTH ORGANIZATION

The Seventh Seminar on the World Health Organization will be held in Minneapolis from May 26 through June 4 simultaneously with the Eleventh World Health Assembly. Physicians and medical students are invited to attend a series of discussions and reports on world aspects of tuberculosis, atomic energy, poliomylitis, leprosy, malaria, ischemic heart disease, and the role of health education in raising standards of health. The Seminar will be held in the Lutheran Brotherhood Building, Minneapolis.

. . . . THE PRESIDENT'S PAGE . . . .

THE State Medical Society of Wisconsin is a dynamic organization dedicated to better and more modern medical services, all in the finest tradition of Wisconsin medicine.

A spirit of progress has been reflected during the past year in all the activities that have been carried on through cooperative efforts of all the several sectors of the society structure. I feel that we owe a vote of gratitude to the many devoted men and women who have defied time, distance and the elements in actively and diligently serving on the many and various state and county committees.

The fine work of these committees carried on with the help and guidance of an extraordinarily capable and efficient home office staff has accrued to making the activities of the past 12 months another jewel in the diadem of traditional Wisconsin medicine.

The record of achievement and problems of Wisconsin medicine for the past year will by long established custom be formally presented to the House of Delegates at the annual meeting during the first week of May.

Now, in this pre-meeting message to you, allow me to discuss briefly, again, what I consider to be organized medicine's greatest problem.

In my inaugural address, I declared that unity would be the major theme of my administration. Now, after 12 months, I am convinced that it remains our major defection.

I would like to direct your attention not to unity as such, but rather to one of the essential ingredients of this laudable quality of human behavior. As vanadium is added to iron to make the resulting product tougher and more serviceable, so must an ingredient be added to human behavior in the effort to establish a more practical and effective form of cooperative social conduct.

Like unity and loyalty, this ingredient is something intangible yet real in the sense that the eternal verities, Faith, Hope and Charity, are real.

Like Unity and Loyalty it can never be bought—it must be earned.

It differs from the usual types of unity and loyalty, which too often are illusionary and evanescent in character, in that it is acquired in what is commonly known as the hard way. The further difference lies in the well known fact that when once acquired it becomes an almost ineradicable factor in the subsequent pattern of life.

What is this thing of which I speak?

The fame of the American Marines and the French Foreign Legion is based on this particular quality of human behavior.

The amazing French to whom mankind is indebted for so much of our cultural progress expressed it in this very significant phrase, esprit de corps.

The definition of this well known but not always well understood phrase is taken from Webster's New International Dictionary. "The common spirit pervading the members of a body or association. It implies sympathy, enthusiasm, devotion and a jealous regard for the body as a whole."

I respectfully invoke your sincere and thoughtful concern of a badly cracked stone in the foundation of the House of Medicine to the end that "Having done all, to stand".

Harry E. Kasten, M.D.

1958 Annual Meeting Program

Milwaukee Auditorium and Hotel
Schroeder, Milwaukee
MAY 6-7-8, 1958

1958 ANNUAL MEETING TIMETABLE

MONDAY, MAY 5

5:00 p.m. New Delegates and Alternates Meeting
7:30 p.m. House of Delegates

TUESDAY, MAY 6—GENERAL PRACTICE DAY

8:00 a.m. Registration and Exhibits Open
9:00 a.m. General Session
9:30 a.m. Reference Committees, House of Delegates
12:15 p.m. Round-Table Luncheons
12:15 p.m. Luncheons of Marquette University School of Medicine and University of Wisconsin Medical School alumni associations
2:00 p.m. General Session
6:00 p.m. Buffet for Delegates and Alternates
7:30 p.m. House of Delegates

WEDNESDAY, MAY 7

8:00 a.m. Registration and Exhibits Open
9:00 a.m. House of Delegates
9:00 a.m. General Session
9:00 a.m. Special Program on Internal Medicine by Residents
12:15 p.m. Round-Table Luncheons
12:15 p.m. Luncheon, Charitable, Educational, and Scientific Foundation
12:15 p.m. Luncheon, Wisconsin Clinic Managers Association
2:00 p.m. Special Programs on Internal Medicine, Obstetrics and Gynecology, Psychiatry, Radiology, Surgical Problems
6:15 p.m. President's Reception
7:00 p.m. Annual Dinner

THURSDAY, MAY 8

8:00 a.m. Registration and Exhibits Open
9:00 a.m. General Session
12:15 p.m. Round-Table Luncheons
12:15 p.m. Past President's Luncheon
2:00 p.m. Special Programs on Anesthesia, Gastroenterology, Ophthalmology and Otolaryngology, Pediatrics, Surgery

THE 1958 PROGRAM

This year's Annual Meeting scientific programs were prepared under the direction of Kenneth E. Lemmer, M.D., Madison, in cooperation with the Council on Scientific Work of the State Medical Society and representatives of the several sections of the Society and specialty organizations in Wisconsin.

COUNCIL ON SCIENTIFIC WORK

L. G. KINDSCHI, M.D.
Monroe
Chairman

KENNETH E. LEMMER, M.D.
Madison
Program Chairman

M. F. HUTH, M.D.
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Milwaukee
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School of Medicine

R. S. BALDWIN, M.D.
Marshfield
Medical Editor,
The Wisconsin Medical Journal

to These Annual Meeting Details . . . .

★ **REGISTRATION:** Pick up your badge at the registration desk, inside of main entrance of Milwaukee Auditorium, Fifth and Kilbourn Streets. The time: Tuesday, 8:00 a.m.–4:30 p.m.; Wednesday and Thursday, 8:00 a.m.–4:00 p.m. Admittance by badge only.

★ **CERTIFIED GUESTS:** Medical students, medical assistants and hospital personnel will be admitted on Thursday (after 12 noon). Interns and residents admitted without registration fee, if certified by hospital. Members of the Wisconsin State Dental Society and out-of-state physicians who are members of their county and state medical societies admitted by membership cards.

★ **VA AND M.D.'s IN MILITARY SERVICE:** Members of the Veterans Administration must be members of the State Medical Society to be admitted. Physicians in the armed services admitted by presenting certification of current military status.

★ **TELEPHONE SERVICE:** At Milwaukee Auditorium—During scientific sessions, calls to physicians other than Milwaukee doctors should be directed to BR 1–9609 or BR 1–9610. Calls for Milwaukee doctors should be directed through Physicians Service Bureau—BR 1–4131—and they will be transmitted to a staff member of the Medical Society of Milwaukee County. At the Hotel Schroeder—Delegates can be reached during sessions of the House by having calls directed to the phone in the fifth floor foyer—BR 1–7250. Those attending luncheons at the hotel can be reached in the same manner between 12 noon and 1:45 p.m. If you are attending luncheons, inform your secretary of your schedule, so you can be located promptly. Give her as much information as possible as to your whereabouts.

★ **RESERVATIONS FOR ANNUAL DINNER:** May be obtained at the registration desk in the Auditorium from 8:00 a.m. to 4:00 p.m. Tuesday and Wednesday. Attendance at the dinner Wednesday night by ticket only. Limit 450.

DEAR DOCTOR!

The 117th Annual Meeting of the State Medical Society of Wisconsin promises to be one of great appeal to every one of its members. Every effort has been made to schedule the finest speakers available, to arrange meetings in accordance with the needs and desires of Wisconsin physicians, and to include subjects of the greatest interest to every one.

★

I urge you to attend meetings of major concern to your practice, to visit exhibits, to plan to take part in the Round-Table Luncheons, and to join us at the Annual Meeting Dinner on Wednesday evening. You and your lady are invited, too, to the reception for Mrs. Kasten and myself, as my term as President of the Society ends. I hope you will take that opportunity, also, to welcome Jerome W. Fons, M.D., as he prepares to assume that office.

★

There are many associated functions of interest, and each was scheduled with you in mind. You will take home much more from our Annual Meeting if you take advantage of the excellent programs, from general session to alumni gatherings, on the calendar.

★

I will look for you May 6–7–8.

H. E. KASTEN, M.D.
President

★ **RESERVATIONS FOR NOON LUNCHEONS:** For Round Tables, at registration desk between 8:00 a.m. and 11:00 a.m., starting Tuesday, May 6. If any tickets remain unsold by 11:00 a.m. the day of the luncheon, they can be purchased in fifth floor foyer, Hotel Schroeder.

★ **RESERVATIONS FOR GOLF TOURNAMENT:** Get in touch with Mr. A. H. Luthmers, Medical Society of Milwaukee County, 756 N. Milwaukee St., Milwaukee 2. Phone—BR 1–4131. $10.00 covers all costs, including green fees and dinner. The place—North Shore Country Club, 134 E. Fairy Chasm Road, Milwaukee. Tee off at 10:30 a.m., Monday, May 5. Dinner and presentation of awards, 7:30 p.m. Luncheon available at the club.

PROGRAM

MONDAY, MAY 5

5:00 p.m. New Delegates and Alternates Meeting

7:30 p.m. House of Delegates

★

TUESDAY, MAY 6

GENERAL PRACTICE DAY

Sponsored by the Wisconsin Academy of General Practice. Meetings open to all physicians. **Approval has been given to permit Academy members to qualify for six hours of formal credit in Category 1.**

8:00 a.m.—Registration Opens, Milwaukee Auditorium
Scientific Exhibits Open, Milwaukee Auditorium

9:00 a.m.—Reference Committees, House of Delegates
Rooms 507, 508, Pine Room and Ballroom, Hotel Schroeder

★

GENERAL SESSION

PLANKINTON HALL, AUDITORIUM

Moderator: T. J. NEREIM, M.D., Madison, *President, Wisconsin Academy of General Practice*

9:00 a.m.—"Problems of Fractures Commonly Seen in General Practice"
Moderator: JAMES R. REGAN, M.D., Milwaukee
Panel participants: JAMES W. STACK, M.D., Chicago, *Associate Professor of Orthopedic Surgery, Northwestern University Medical School*
HUGH HICKEY, M.D., Milwaukee, *Clinical Instructor of Orthopedic Surgery, Marquette University School of Medicine*
JOHN VAN DRIEST, M.D., Sheboygan

10:15 a.m.—Recess to View Exhibits

11:00 a.m.—"Office Gynecology"
JACK KLIEGER, M.D., Milwaukee, *Assistant Clinical Professor of Obstetrics and Gynecology, Marquette University School of Medicine*

11:30 a.m.—"Cardiac Effects of Athletic Work Stress"
J. W. WILCE, M.D., Columbus, Ohio, *Director, University Health Service, Ohio State University*
(Lucy Droessel Memorial Lecture of the Wisconsin Heart Assn.)

J. W. WILCE, M.D.
COLUMBUS, OHIO

Doctor Wilce will report on a 27-year study of 237 athletes which covered cardiac effects of athletic stress. Review, analysis and modernization of previous group findings will be advanced, as will reinterpretation, rationalization and clarification of the term, Athletic Heart, on the basis of clinical evidence. Doctor Wilce appears on the program under the sponsorship of the Wisconsin Heart Association.

★

TUESDAY NOON

ROUND-TABLE LUNCHEONS

HOTEL SCHROEDER

12:15 p.m.

"Care of the Diabetic Patient"
English Room, Fifth Floor
HOWARD ROOT, M.D., Boston, Massachusetts
Moderator: MAURICE HARDGROVE, M.D., Milwaukee

"Medical Aspects of the Current Athletics and Sport Picture"
Pere Marquette Room, Fifth Floor
J. W. WILCE, M.D., Columbus, Ohio
Moderator: ANTHONY R. CURRERI, M.D., Madison

"The Evaluation of the Infant or Child Slow in Physical Development"
Room 507
JOHN C. MACQUEEN, M.D., Iowa City, Iowa
Moderator: JOHN GARVEY, M.D., Milwaukee

"The Private Physician and His Relationship to the Public Health Programs"
Room 508
JOHN S. DETAR, M.D., Milan, Michigan
Moderator: J. C. GRIFFITH, M.D., Milwaukee

★

SPECIAL ASSOCIATED FUNCTIONS

12:15 p.m.

Marquette University Medical Alumni Association Luncheon
Market Hall, Milwaukee Auditorium
Secure ticket by writing Ray Pfau, 620 N. 14th St., Milwaukee 8. Price: $2.00

Wisconsin Alumni Association Luncheon
East Room, Fifth Floor, Hotel Schroeder
Secure your ticket by writing Robert C. Parkin, M.D., 418 N. Randall Ave., Madison 6. Price: $2.50

TUESDAY AFTERNOON

GENERAL SESSION

PLANKINTON ROOM, AUDITORIUM

Moderator: DAVID N. GOLDSTEIN, M.D., Kenosha, President-Elect, Wisconsin Academy of General Practice

2:00 p.m.—"Placebos and Tranquilizers"

DAVID T. GRAHAM, M.D., Madison, *Associate Professor of Medicine, University of Wisconsin Medical School*

2:30 p.m.—"The Organic Explanation of Some Behavior Disturbances"

JOHN C. MACQUEEN, M.D., Iowa City, Iowa, *Associate Professor of Pediatrics, State University of Iowa*

3:00 p.m.—Recess to View Exhibits

3:45 p.m.—"Oral Preparation for the Treatment of Diabetes"

HOWARD ROOT, M.D., Boston, Massachusetts, *Medical Director of the Joslin Clinic, Harvard Medical School*

HOWARD ROOT, M.D.
BOSTON, MASSACHUSETTS

The development of new oral drugs for the treatment of diabetes suggests a review of results to date and an evaluation of their effectiveness in relation to former modes of therapy.

4:15 p.m.—"Cancer Detection in the Office of the Generalist"

JOHN S. DE TAR, M.D., Milan Michigan, *Past President of the American Academy of General Practice*

BLUE SHIELD . . .

Representatives will be available to answer questions and provide information about coverage, claims and enrollment. Visit our booth on the Auditorium stage!

JOHN S. DE TAR, M.D.
MILAN, MICHIGAN

Doctor De Tar will outline his contention that success of the generalist in the fight against cancer will be in direct proportion to his index of cancer consciousness and suspicion, in which he must maintain a healthy titre. Examples will be shown in cancer detection in the salivary glands, thyroid, breast, stomach, recto-sigmoid, cervix and in the field of hematology.

★

TUESDAY EVENING

6:00 p.m.—Buffet for Delegates and Alternates
Pere Marquette Room, Hotel Schroeder

7:30 p.m.—House of Delegates
Ballroom, Hotel Schroeder

★

WEDNESDAY, MAY 7

8:00 a.m.—Registration Opens, Milwaukee Auditorium

Scientific Exhibits Open, Milwaukee Auditorium

9:00 a.m.—House of Delegates
Ballroom, Hotel Schroeder

WISCONSIN CHAPTER AMERICAN COLLEGE OF CHEST PHYSICIANS

Annual Meeting

May 5, Schroeder Hotel, Milwaukee

PROGRAM

1:00 p.m.—Registration, Serpentine Room, Lobby

2:00 p.m.—**Speakers**
John R. McDonald, M.D., Rochester, Minn.; Edwin R. Levine, M.D., Chicago; Jerome L. Marks, M.D., Milwaukee; George R. Meneely, M.D., Nashville, Tenn., and Aldo A. Luisada, M.D., Chicago

Subjects
Pulmonary Lesions, Effects of Exercise in Pulmonary Emphysema, Radiation Hazards, Heart Sounds in Clinical Medicine. Also, a panel discussion

NO REGISTRATION FEE!

WEDNESDAY, MAY 7

GENERAL SESSION

PLANKINTON HALL, AUDITORIUM

Moderator: L. G. KINDSCHI, M.D., Monroe, *Chairman, Council on Scientific Work*

9:00 a.m.—Symposium on "Cancer of the Cervix"

Moderator: RALPH E. CAMPBELL, M.D., Madison, *President, Wisconsin Society of Obstetrics and Gynecology, Professor of Obstetrics and Gynecology, University of Wisconsin Medical School*

Participants:

JAMES W. REAGAN, M.D., Cleveland, Ohio, *Institute of Pathology, Western Reserve University*

FRANKLIN L. PAYNE, M.D., Philadelphia, *William Goodell Professor and head of the Department of Obstetrics and Gynecology, University of Pennsylvania Medical School*

FRANK SMITH, M.D., New York City, *Professor of Obstetrics and Gynecology, Cornell University Medical College*

(This panel is sponsored by the Milwaukee and Wisconsin divisions of the American Cancer Society)

10:15 a.m.—Recess to View Exhibits

11:00 a.m.—"Perinatal Adjustments"

VIRGINIA APGAR, M.D., New York City, *Professor of Anesthesiology, College of Physicians and Surgeons, Columbia University*

VIRGINIA APGAR, M.D.
NEW YORK, N.Y.

An outline of factors contributing to acute asphyxia during delivery, including decreased uterine blood flow, partial or complete placental separation and cord compression, will be presented by Doctor Apgar.

11:30 a.m.—"Indications For Surgical Treatment of Non-Toxic Nodular Goiter"

CARL W. EBERBACH, M.D., Milwaukee, *Clinical Professor and Director of the Department of Surgery, Marquette University School of Medicine*

SPECIAL PROGRAM ON INTERNAL MEDICINE

(Planned in cooperation with the Wisconsin Society of Internal Medicine and open to all physicians)

KILBOURN HALL, AUDITORIUM

Moderator: PAUL G. LA BISSONIERE, M.D., Milwaukee, *Secretary–Treasurer, Wisconsin Society of Internal Medicine*

9:00 a.m.—"Erythroleukemia with Leukemia Preceding Erythremia"

PAUL CALABRESI, M.D., *Project Associate in Medicine, Department of Medicine, University of Wisconsin Medical School*

9:15 a.m.—"Congenital Hemolytic Anemia"

ARCHIE MAC KINNEY, JR., M.D., Madison, *Research Fellow in Medicine, Department of Medicine, University of Wisconsin Medical School*

9:30 a.m.—"Operative Criteria for Surgical Repair of High Pressure Patent Ductus Arteriosis"

DOUGLAS H. WHITE, JR., M.D., Instructor in *Medicine, University of Wisconsin Medical School*

9:45 a.m.—"The Role of Exercise in the Management of Postural Low Back Pain"

ALBERT M. COHEN, M.D., *Resident Member,* Milwaukee

10:15 a.m.—Recess to View Exhibits

11:00 a.m.—"The Use of I-131 in the Treatment of Thyrotoxicosis; 10 Years' Experience"

D. JOE FREEMAN, M.D., Madison, *Research Fellow in Medicine, Department of Medicine, University of Wisconsin Medical School*

E. C. ALBRIGHT, M.D., Madison, *Associate Professor of Medicine, Department of Medicine, University of Wisconsin Medical School*

E. S. GORDON, M.D., *Professor of Medicine, Department of Medicine, University of Wisconsin Medical School*

11:30 a.m.—"Current Treatment of Ulcerative Colitis"

JAMES W. MANIER, M.D., Marshfield Clinic, Marshfield

WEDNESDAY NOON

ROUND-TABLE LUNCHEONS

HOTEL SCHROEDER

12:15 p.m.

"Diagnosis and Management of Fetal Distress"

East Room, Fifth Floor
FRANKLIN L. PAYNE, M.D., Philadelphia
Moderator: FREDERICK J. HOFMEISTER, M.D., Milwaukee

"Fractures About the Shoulder Joints"

Room 507
ANTHONY DE PALMA, M.D., Philadelphia
Moderator: DAVID J. ANSFIELD, M.D., Milwaukee

"Trauma and Associated Problems of Emergency Care"

Room 508
ROBERT D. PILLSBURY, Lt. Col., M.C., Fort Chaffee, Oklahoma
Moderator: SIDNEY J. WYNN, M.D., Milwaukee

"Practical Advice to the Present and Prospective Coronary Heart Patient"

Pere Marquette Room, Fifth Floor
ANCEL KEYS, Ph.D., Minneapolis
Moderator: J. L. SIMS, M.D., Madison

"Complications of Obstetrical Anesthesia"

Parlor A, Fourth Floor
VIRGINIA APGAR, M.D., New York City
Moderator: GEORGE S. KILKENNY, M.D., Milwaukee

"Some Practical Aspects of Preventive Psychiatry for Children"

Parlor D, Fourth Floor
RALPH D. RABINOVITCH, M.D., Northville, Michigan
Moderator: SARA G. GEIGER, M.D., Milwaukee

"The Solitary Pulmonary Nodule: What is it, and What Should We Do About It?"

Parlor E, Fourth Floor
C. ALLEN GOOD, M.D., Rochester, Minnesota
Moderator: LESTER W. PAUL, M.D., Madison

"Carcinoma in Situ"

Club Rooms, Third Floor
JAMES W. REAGAN, M.D., Cleveland, Ohio
Moderator: ORVILLE R. KELLY, M.D., Wausau

(This luncheon to be followed by business meeting of the Wisconsin Society of Pathologists)

SPECIAL ASSOCIATED FUNCTIONS

12:15 p.m.

Luncheon, Charitable, Educational and Scientific Foundation, Inc.
English Room, Fifth Floor

Luncheon, Wisconsin Clinic Managers Association
Parlor F, Fourth Floor

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WEDNESDAY AFTERNOON

SPECIAL PROGRAM ON INTERNAL MEDICINE

PLANKINTON HALL, AUDITORIUM

Program planned in cooperation with the Wisconsin Society of Internal Medicine and open to all physicians.

Moderator: ROBIN N. ALLIN, M.D., Madison, *President, Wisconsin Society of Internal Medicine*

2:00 p.m.—"Tietze Syndrome—a Report of Four Cases"

AUSTIN J. MCSWEENY, M.D., Janesville

2:30 p.m.—"Electrocardiogram in Pulmonary Emphysema"

RICHARD H. WASSENBERGER, M.D., Madison, *Chief of the Section of Cardiology, Veterans' Hospital*

3:00 p.m.—Recess to view Exhibits

3:45 p.m.—"Lipids in the Diet and the Blood"

ANCEL KEYS, Ph.D., Minneapolis, *Director of the Laboratory of Physiological Hygiene, University of Minnesota Medical School*

ANCEL KEYS, PH.D.
MINNEAPOLIS, MINNESOTA

Major relationships between lipids, diet and development of coronary heart disease, based on new findings, give hope to eventual coronary disease control.

4:15 p.m.—Discussion

SPECIAL PROGRAM ON OBSTETRICS AND GYNECOLOGY

JUNEAU HALL, AUDITORIUM

Program planned in cooperation with the Wisconsin Society of Obstetrics and Gynecology and open to all physicians

Moderator GEORGE S. KILKENNY, M.D., Milwaukee, *Associate Professor of Obstetrics and Gynecology, Marquette University Medical School*

2:00 p.m.—"The Milwaukee Perinatal Death Survey and Its Significance to Medical Practice"

M. ALEX KREMBS, M.D., Milwaukee, *Assistant Clinical Professor of Obstetrics and Gynecology, Marquette University School of Medicine*

2:30 p.m.—"Pelvic Pain"

FRANK R. SMITH, M.D., New York City, *Professor of Obstetrics and Gynecology, Cornell University Medical School*

FRANK R. SMITH, M.D.
NEW YORK, N.Y.

A plan for the management of pelvic pain will be presented by Dr. Smith. Characteristic symptoms and physical findings also will be considered, as will be the possibility of multiplicity of etiology.

3:00 p.m.—Recess to view Exhibits

3:45 p.m.—"Non-Obstetrical Surgical Complications During Pregnancy"

FRANKLIN L. PAYNE, M.D., Philadelphia, *William Goodell Professor and Head of the Department of Obstetrics and Gynecology, University of Pennsylvania Medical School*

FRANKLIN L. PAYNE, M.D.
PHILADELPHIA, PENNSYLVANIA

These complications may be grouped as either intragenital or extragenital. Consideration will be based on literate opinions as well as upon personal experience, in many instances. The management of many such complications is established while that of others remains controversial.

4:15 p.m.—"Delivery Room Diagnosis"

VIRGINIA APGAR, M.D., New York City, *Professor of Anesthesiology, College of Physicians and Surgeons, Columbia University*

5:00 p.m.—Business meeting of the Wisconsin Society of Obstetrics and Gynecology

SPECIAL NOTICE!

Meetings of the House of Delegates are regarded as among the most important functions of the Annual Meeting of the State Medical Society. Reports of the officers and committees, as well as new business, will be presented at the initial session of the House at 7:30 p.m. Monday, May 5.

On Tuesday morning at 9:00, the reference committees will meet.

It is a privilege as well as an opportunity for any member of the Society to appear before these committees and present his views on any matter properly before them. Any member, whether he wishes to appear before the committees or merely to listen in on their deliberations, is urged to participate in this extremely important phase of Society activities.

You are also invited to attend the other sessions of the House at 7:30 p.m. Tuesday and 9:00 a.m. Wednesday.

SPECIAL PROGRAM ON PSYCHIATRY

KILBOURN HALL, AUDITORIUM

This program planned in cooperation with the Milwaukee Neuro-Psychiatric Society and open to all physicians

Moderator: EDWARD C. SCHMIDT, M.D., Milwaukee, *Secretary, Milwaukee Neuro-Psychiatric Society*

2:00 p.m.—"Emotional Disorders in Children"

RALPH D. RABINOVITCH, M.D., *Director, Hawthorn Center,* Northville, Michigan

(Rogers Memorial Lecture of the Rogers Memorial Sanitarium, Oconomowoc)

RALPH D. RABINOVITCH, M.D.
NORTHVILLE, MICHIGAN

Modern concepts of extreme emotional disturbance in children will be outlined by Doctor Rabinovitch, based upon experience and programs conducted in other areas of the country.

3:00 p.m.—Recess to view Exhibits

3:45 p.m.—"The Treatment of Emotionally Disturbed Children in Wisconsin"

Moderator: HAROLD F. BORENZ, M.D., *Assistant Professor of Psychiatry, University of Wisconsin Medical School,* Madison

KEITH M. KEANE, M.D., Appleton

BERNARD KAUFMAN, M.D., Milwaukee

L. J. GANSER, M.D., *Assistant Clinical Professor of Psychiatry, University of Wisconsin Medical School,* Madison

JAMES A. JOHNSON, M.D., *Milwaukee Guidance Clinic*

SPECIAL PROGRAM ON RADIOLOGY

WALKER HALL, AUDITORIUM

This program planned in cooperation with the Wisconsin Radiologic Society and open to all physicians

Moderator: LESTER W. PAUL, M.D., Madison

2:00 p.m.—"Role of Radiation Therapy in the Treatment of Carcinoma of the Breast"

HALVOR VERMUND, M.D., Madison, *Professor of Radiology, University of Wisconsin Medical School*

CHARLES BENKENDORF, M.D., Madison, *Senior Resident in Radiology, University of Wisconsin Medical School*

2:30 p.m.—"Roentgen Aspects of the Lymphomas and Certain Blood Dyscrasias"

EARL E. BARTH, M.D., Chicago, *Professor and Chairman, Department of Radiology, Northwestern University Medical School*

EARL E. BARTH, M.D.
CHICAGO, ILLINOIS

Doctor Barth will stress the value of an adequate roentgen study in the diagnosis and treatment of the lymphomas, as well as the importance of teamwork between the referring physician and the radiologist. Also to be discussed, the importance of a chest examination and a scout film of the abdomen before considering more specialized procedures.

3:00 p.m.—Recess to view Exhibits

3:45 p.m.—"The Value of the Venous Phase in Diagnosis in Cerebral Angiography"

MARVIN J. ROESLER, M.D., Milwaukee, *Resident in Radiology, Columbia Hospital*

4:15 p.m.—"X-Ray Diagnosis of Diseases of the Esophagus"

C. ALLEN GOOD, M.D., Rochester, Minnesota, *Professor of Radiology, Mayo Foundation, Graduate School, University of Minnesota*

C. ALLEN GOOD, M.D.
ROCHESTER, MINNESOTA

Methods of roentgenologic examination of the esophagus will be covered by Doctor Good. He intends to touch on the signs of the more important conditions affecting this organ, and stress treatment of lesions concerned with diverticulum, achalasia and diffuse spasm, benign and malignant tumors, esophageal hiatal hernia, varices, strictures and esophagitis.

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SPECIAL PROGRAM ON SPECIFIC SURGICAL PROBLEMS

ENGELMANN HALL, AUDITORIUM

(Open To All Physicians)

Moderator: KENNETH E. LEMMER, M.D., Madison, *Professor of Surgery, University of Wisconsin Medical School, and Program Chairman, 1958 Annual Meeting*

2:00 p.m.—"Neurosurgical Management of Pain"

M. J. JAVID, M.D., Madison, *Associate Professor of Surgery, University of Wisconsin Medical School*

2:30 p.m.—"Diseases About the Shoulder"

ANTHONY F. DE PALMA, M.D., Philadelphia

ANTHONY F. DE PALMA, M.D.
PHILADELPHIA, PENNSYLVANIA

Pathology of diseases of the shoulders will be explained by Doctor De Palma, with particular emphasis on classification as to method of treatment. A description of usual and unusual complications, together with management and treatment, is planned.

3:00 p.m.—Recess to view Exhibits

3:45 p.m.—"Diaphragmatic Rupture: A Lethal Danger in Civilian Trauma"

WILSON WEISEL, M.D., Milwaukee, *Assistant Clinical Professor of Surgery, Marquette University School of Medicine*

4:15 p.m.—"Treatment of Burns and Associated Problems of Therapy"

ROBERT D. PILLSBURY, Lt. Col., M.C., Fort Chaffee, Oklahoma, *Chief, Surgical Service, U. S. Army Hospital*

WEDNESDAY EVENING

6:15 p.m.—President's Reception

East Room, Hotel Schroeder

State Medical Society members and their ladies are invited to the reception for Dr. and Mrs. H. E. Kasten. The reception will honor the completion of Dr. Kasten's term as president of the society.

H. E. KASTEN, M.D.
President

J. E. FONS, M.D.
President-Elect

7:00 p.m.—Annual Dinner

Ballroom, Hotel Schroeder

Fifty Year Club members will receive engraved certificates attesting their long period of medical service. Dr. Jerome W. Fons, Milwaukee, will speak briefly in assuming the presidency of the State Medical Society. The dinner is followed by a presentation of excellent professional talent.

THURSDAY, MAY 8

8:00 a.m.—Registration Opens, Auditorium
Scientific Exhibits Open, Auditorium

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GENERAL SESSION

PLANKINTON HALL, AUDITORIUM

Moderator: MELVIN F. HUTH, M.D., Baraboo, *Chairman, Scientific Luncheons, 1958 Annual Meeting*

9:00 a.m.—"The Anemias and Their Significance to Medical Practice"

Moderator: JOHN S. HIRSCHBOECK, M.D., Milwaukee, *Associate in Medicine and Dean of the Marquette University School of Medicine*

Participants:

HOWARD ALT, M.D., Chicago, *Professor of Medicine, Northwestern University School of Medicine*

ROBERT SCHILLING, M.D., Madison, *Associate Professor of Medicine, University of Wisconsin Medical School*

ANTHONY PISCIOTTA, M.D., Milwaukee, *Associate Professor of Medicine, Marquette University School of Medicine*

10:15 a.m.—Recess to view Exhibits

11:00 a.m.—"The Life and Work of William Beaumont"

BURRILL B. CROHN, M.D., New York City, *Consultant in Gastroenterology to the Mt. Sinai Hospital and to Columbia University, Graduate Medicine*

(William Beaumont Memorial Lecture)

BURRILL B. CROHN, M.D.
NEW YORK, N.Y.

The life and experiments of Beaumont, compared with modern physiological principles and psychosomatic concepts, will be outlined. Comparisons also with modern medical management.

11:30 a.m.—"Abdominal Trauma"

EDWARD A. BACHHUBER, M.D., Milwaukee, *Associate Dean and Associate Professor of Surgery, Marquette University School of Medicine*

THURSDAY NOON

ROUND-TABLE LUNCHEONS

HOTEL SCHROEDER

"Neonatal Surgical Emergencies"
Pere Marquette Room, Fifth Floor
MARK RAVITCH, M.D., Baltimore, Maryland
Moderator: SHIMPEI SAKAGUCHI, M.D., Milwaukee

Section on Ophthalmology and Otolaryngology
East Room, Fifth Floor
(Luncheon followed by scientific program. See page 21)

"The Hazards of Anesthesia"
English Room, Fifth Floor
HAROLD R. GRIFFITH, M.D., Montreal, Canada
Moderator: L. F. THURWACHTER, JR., M.D., Milwaukee

"Management of Peritonitis in Infancy"
Room 507
RICHARD H. SEGNITZ, M.D., Lexington, Kentucky
Moderator: THOMAS V. GEPPERT, M.D., Madison

"Practical Hints in the Management of Common Skin Diseases"
Room 508
LOUIS A. BRUNSTING, M.D., Rochester, Minnesota
Moderator: DAVID W. KERSTING, M.D., Milwaukee

"Current Therapy of Leukemia and the Lymphomas"
Parlor A, Fourth Floor
HOWARD L. ALT, M.D., Chicago
Moderator: JOHN S. HIRSCHBOECK, M.D., Milwaukee

"The Most Recent Developments in Regional Ileitis"
Parlor D, Fourth Floor
BURRILL B. CROHN, M.D., New York City
Moderator: M. C. F. LINDERT, M.D., Milwaukee

SPECIAL ASSOCIATED FUNCTION

12:15 p.m.

Past President's Luncheon
Parlor G, Fourth Floor
Host: HARRY E. KASTEN, M.D., Beloit, outgoing president
Special Guest: JEROME W. FONS, M.D., Milwaukee, incoming president

★

A GRAND OPPORTUNITY . . .

to further the cause of Wisconsin's rich medical heritage.

The efforts of physicians and their wives, working together as members of the Section on Medical History, are essential in preserving and encouraging this heritage.

To create the Medical Museum of Wisconsin at Prairie du Chien, soon to be a reality, to collect valuable equipment, pictures, diaries, documents, daybooks and other papers, your wholehearted support and enthusiasm are necessary. Together with the State Historical Society of Wisconsin, the Section also strives to preserve manuscripts recording medical history of our state. A panoramic view of the Museum is shown above as it will be when completed.

You may join the Section on Medical History (dues $5 annually) by writing to the State Medical Society, Box 1109, Madison 1. The rewards and personal satisfaction to be derived from participating in the Section's various projects are endless.

SPECIAL ASSOCIATED FUNCTIONS . . .

ON MONDAY—Golf Tournament, North Shore Country Club, 10:30 a.m.

TUESDAY NOON—Luncheons of the University of Wisconsin Medical School and Marquette University School of Medicine Alumni Associations

WEDNESDAY NOON—Luncheon, Charitable, Educational and Scientific Foundation
Luncheon, Wisconsin Clinic Managers Association

WEDNESDAY NIGHT—Annual Dinner and President's Reception, 6:15 p.m.

THURSDAY NOON—Past President's Luncheon

THURSDAY AFTERNOON

SPECIAL PROGRAM ON ANESTHESIA

KILBOURN HALL, AUDITORIUM

This program was planned in cooperation with the Wisconsin Society of Anesthesiologists and open to all physicians

Moderator: L. F. THURWACHTER, M.D., Milwaukee, *President, Wisconsin Society of Anesthesiologists*

2:00 p.m.—"Present Concepts of Muscular Relaxants"

HAROLD R. GRIFFITH, M.D., Montreal, Canada, *Medical Superintendent and Anaesthetist-in-Chief; Emeritus Professor of Anaesthesia, McGill University*

HAROLD R. GRIFFITH, M.D.
MONTREAL, CANADA

Doctor Griffith will explain the controversy as to the "inherent toxicity" of curare and curare-like drugs and how it has subsided into a better understanding of how to use them safely. Of available relaxant drugs, succinylcholine seems to be the most advantageous on account of its short action and controllability.

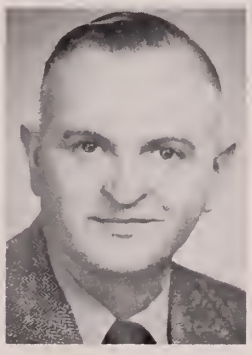
2:30 p.m.—"Use of Electro-Encephalography in Anesthesia"

MARTIN J. DENIO, M.D., Milwaukee
ANNE E. ROETHKE, M.D., Milwaukee

3:00 p.m.—Recess to view Exhibits

3:45 p.m.—"Hypnosis in Anesthesia and Medical Practice Generally"

VINCENT J. VAUGHN, M.D., Ottumwa, Iowa



VINCENT J. VAUGHN, M.D.
OTTUMWA, IOWA

The contention that hypnosis can be used daily as an adjunct to other anesthetic techniques will be described by Doctor Vaughn. It will be based on the theory that the anesthesiologist is in an ideal situation to use hypnosis because of problems encountered which deal with fear, pain, nausea and post-operative mobilization.

4:15 p.m.—Discussion

5:00 p.m.—Business meeting of the Wisconsin Society of Anesthesiologists

SPECIAL PROGRAM ON GASTROENTEROLOGY

JUNEAU HALL, AUDITORIUM

This program was planned in cooperation with the Milwaukee Gastroenterology Society and open to all physicians

Moderator: M. C. F. LINDERT, M.D., Milwaukee, *President of the Milwaukee Gastroenterology Society*

2:00 p.m.—"Management of the Complicated Duodenal Ulcer"

JOSEPH SHAIKIN, M.D., Milwaukee, *Associate Clinical Professor of Medicine, Marquette University School of Medicine*
Discussant: BURRILL B. CROHN, M.D., New York City

2:20 p.m.—"Esophagitis"

MICHAEL W. SHUTKIN, M.D., Milwaukee, *Assistant Clinical Professor of Medicine, Marquette University School of Medicine*

2:40 p.m.—"Current Considerations of Acute Hepatic Diseases"

M. C. F. LINDERT, M.D., Milwaukee, *Associate Clinical Professor of Medicine, Marquette University School of Medicine*

3:00 p.m.—Recess to view Exhibits

3:45 p.m.—"Hemorrhage, Its Medical and Surgical Management"

BURRILL B. CROHN, M.D., New York City

4:15 p.m.—Question and Answer session on previous presentations

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SPECIAL PROGRAM ON OPHTHALMOLOGY AND OTOLARYNGOLOGY

EAST ROOM, FIFTH FLOOR, HOTEL SCHROEDER

This program was planned in cooperation with the Section on Ophthalmology and Otolaryngology and open to all physicians

Moderator: RALPH P. SPROULE, M.D., Milwaukee

1:00 p.m.—Business meeting of the Section

1:30 p.m.—"End Results of Eye Muscle Surgery"

A. D. RUEDEMANN, M.D., Detroit, *Professor of Ophthalmology, Wayne University College of Medicine*

A. D. RUEDEMANN, M.D.
DETROIT, MICHIGAN

A summary of results from a developmental and neurophysiological viewpoint, new concepts of surgery and types of treatment will be outlined.

2:15 p.m.—"The Present Status of Chorioretinitis"

RALPH T. SPROULE, M.D., Milwaukee

2:45 p.m.—"Swellings of the Neck"

BRUCE PROCTOR, M.D., Detroit, *Clinical Associate Professor of Otolaryngology, Wayne University College of Medicine*

3:00 p.m.—Recess to view Exhibits

BRUCE PROCTOR, M.D.
DETROIT, MICHIGAN

An approach to diagnosis of various swellings will be presented by Doctor Proctor. These include congenital anomalies, swellings arising in the common glandular structures, in unusual gland structures; specific nonglandular swellings, hernias projecting into the neck, granulomatous swellings, tumors and abscesses.

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SPECIAL PROGRAM ON PEDIATRICS

WALKER HALL, AUDITORIUM

This program was planned in cooperation with the Wisconsin Academy of Pediatrics and open to all physicians

Moderator: LLOYD M. SIMONSON, M.D., Sheboygan, *President, Wisconsin Academy of Pediatrics*

2:00 p.m.—"Recent Advances in Disorders of the Blood in Children"

NATHAN J. SMITH, M.D., Madison, *Professor and Chairman of the Department of Pediatrics, University of Wisconsin Medical School*

2:30 p.m.—"Systemic Lupus Erythematosis and Dermatomyositis in Childhood"

LOUIS A. BRUNSTING, M.D., Rochester, Minnesota, *Head of Section on Dermatology, Mayo Clinic*

"FIFTY YEAR CLUB"

Twenty fine gentlemen of medicine, in active practice for a half century, will be honored at the Annual Dinner of the State Medical Society on Wednesday evening, May 7.

In recognition of this long, outstanding period of service, the following physicians will be granted certificates and pins as newly qualified members of this exclusive club:

EARL L. BAUM, M.D.	Milwaukee
MAX BORNSTEIN, M.D.	Milwaukee
FREDERICK C. CHRISTENSEN, M.D.	Racine
LEURNER E. CREASY, M.D.	Monroe
HERMAN F. DERGE, M.D.	Eau Claire
MARY P. GRATIOT, M.D.	Shullsburg
ROBERT H. GRAY, M.D.	Onalaska
WILLIAM L. HERNER, M.D.	Milwaukee
JOHN H. HOGAN, M.D.	Racine
F. C. HUFF, M.D.	Sturgeon Bay
THOMAS A. JUDGE, M.D.	Milwaukee
HARRY M. KAY, M.D.	Madison
ISAAC E. LEVITAS, M.D.	Green Bay
W. H. McGUIRE, M.D.	Janesville
HOMER H. MORTON, M.D.	Dodgeville
IRVING E. SCHIEK, M.D.	Rhinelander
T. D. SMITH, M.D.	Neenah
BERT J. STEVES, M.D.	Menomonie
FRED B. WELCH, M.D.	Janesville
JOHN E. ZIEGLER, M.D.	Eau Claire

LOUIS A. BRUNSTING, M.D.
ROCHESTER, MINNESOTA

Incidence, diagnosis and the course of lupus erythematosus will be detailed by Doctor Brunsting. A comparison will be made with dermatomyositis. Significant laboratory procedures for aid in diagnosis and estimation of prognosis will be emphasized. Use of steroids in control of symptoms will be discussed.

3:45 p.m.—"The Problem of Histoplasmosis"

KENNETH R. WILCOX JR., M.D., Atlanta, Georgia, *Epidemiology Intelligence Service, Communicable Disease Center, U.S.P.H.S., assigned to the Wisconsin State Board of Health*

KENNETH R. WILCOX JR., M.D.
ATLANTA, GEORGIA

A case of acute disseminated histoplasmosis of an infant will be described by Doctor Wilcox, bringing in use of the histoplasmin skin test, complement fixation tests and culture in the diagnosis. He will also discuss the distribution of the organism in nature, methods of spread and use of amphotericin B in treatment.

4:15 p.m.—"The Vomiting Infant, a Medico-Surgical Problem"

RICHARD H. SEGNITZ, M.D., Lexington, Kentucky

RICHARD H. SEGNITZ, M.D.
LEXINGTON, KENTUCKY

Doctor Segnitz will define the breadth and depth of current medical problems in connection with his subject, giving a workable differential diagnosis with illustrative cases to indicate how one may separate the major concerns. A few comments on basic surgical principles will be added.

REMEMBER . . .

Be sure to attend at least one session of the House of Delegates: Monday evening at 7:30 p.m., Tuesday at 7:30 p.m. or Wednesday at 9:00 a.m.

SPECIAL PROGRAM ON SURGERY

PLANKINTON HALL, AUDITORIUM

This program was planned in cooperation with the Wisconsin Surgical Society and open to all physicians

Moderator: JOSEPH KING, M.D., Milwaukee, *President, Wisconsin Surgical Society, and Associate Professor of Surgery, Marquette University School of Medicine*

2:00 p.m.—"Present Status of Chemotherapy for Solid Tumors"

ANTHONY R. CURRERI, M.D., Madison, *Professor of Surgery and Director, Cancer Research Hospital, University of Wisconsin Medical School*

2:30 p.m.—"Surgical Approach to Ulcerative Colitis"

MARK M. RAVITCH, M.D., Baltimore, Maryland, *Associate Professor of Surgery, John Hopkins University School of Medicine*

MARK M. RAVITCH, M.D.
BALTIMORE, MARYLAND

Long years of semi-invalidism, recurring hospitalizations and the serious risk of ultimate development of cancer in the colon or rectum will be stressed by Doctor Ravitch as reasons for advisability of ileostomy and resection of the colon in well established advanced disease. Operative procedures and post-operative care also will be outlined.

3:00 p.m.—Intermission

3:15 p.m.—"Biopsy Techniques for Intrathoracic Disease"

BEN R. LAWTON, M.D., Marshfield Clinic, Marshfield

3:45 p.m.—"Salvaging the Burned Hand"

WILLIAM H. FRACKELTON, M.D., Milwaukee

4:00 p.m.—"Responsibilities of Authorship"

KENNETH E. LEMMER, M.D., Madison *(Presidential Address, Wisconsin Surgical Society)*

4:30 p.m.—Business Meeting, Wisconsin Surgical Society

ADDITIONAL GUEST SPEAKERS

LT. COL. R. D. PILLSBURY
Ft. Chaffee, Ark.

HOWARD ALT, M.D.
Chicago

JAMES K. STACK, M.D.
Chicago

J. W. REAGAN, M.D.
Cleveland

NOTE!

These specialty programs are open to all members of the State Medical Society:

Internal Medicine—Wednesday
Obstetrics and Gynecology—Wednesday
Psychiatry—Wednesday
Radiology—Wednesday
Surgery—Wednesday
Anesthesia—Thursday
Gastroenterology—Thursday
Ophthalmology and Otolaryngology—Thursday
Pediatrics—Thursday
Surgery—Thursday

ASSOCIATED DINNERS

WISCONSIN RADIOLOGICAL SOCIETY

(Members Only)

University Club, Milwaukee, May 7

Cocktails at 6:15 p.m.
Dinner at 7:00 p.m.

Speaker: Earl E. Barth, M.D., Northwestern University School of Medicine, Chicago

Reservations ($5, including gratuities) through Farrell F. Golden, M.D.
5221 Tonyawatha Trail
Madison 4

WISCONSIN SURGICAL SOCIETY

(Members and Wives Only)

Milwaukee Athletic Club, May 8

Cocktails at 6:00 p.m.
Dinner at 7:00 p.m.

Speaker: Mark M. Ravitch, M.D., Baltimore, Md.
"Landmarks in Pediatric Surgery"

Reservations ($6) through James M. Sullivan, M.D.
161 W. Wisconsin Ave.
Milwaukee 3

WISCONSIN DERMATOLOGICAL DINNER

May 8

Speaker: Louis A. Brunsting, M.D.
Rochester, Minn.

(Details from Daniel E. Hackbarth, M.D., 161 West Wisconsin Avenue, Milwaukee 3, Secretary Treasurer, Wisconsin Dermatological Society)

WISCONSIN CHAPTER, AMERICAN ACADEMY OF PEDIATRICS

and Pediatrics Section, State Medical Society

University Club, Milwaukee
Thursday, May 8

Cocktails at 6:30 p.m.
Dinner at 7:00 p.m.

Speaker: Richard H. Segnitz, M. D.
Lexington, Ky.
"Seldom Encountered Vascular Bed Tumors in Infancy and Childhood"

Send reservation checks ($5.50) to Karl H. Beck, M. D.
949 Glenview Ave., Wauwatosa, Wis.

SCIENTIFIC EXHIBITS AND DEMONSTRATIONS

Listed below are the educational exhibits which are provided through the cooperation of the indicated hospitals, physicians, and organizations. You are urged to spend part of your recess time in viewing these scientific displays.

The Council on Scientific Work is appreciative of the cooperation accorded it in providing these exhibits as a part of the scientific program.

M. C. F. Lindert, M. D.
Chairman, Scientific Exhibits

M. C. F. Lindert, M. D.
Chairman,
Scientific Exhibits

20—SYNDROMES ASSOCIATED WITH THE PROTRUDING CERVICAL INTERVERTEBRAL DISC

A. Yale Gerol, M. D., Monroe Clinic, Monroe

The syndrome of the cervical disc is based upon the site of protrusion of intervertebral material, *i.e.*, whether midline or lateral.

The exhibit covers 35 cases and demonstrates the proposed method of conservative therapy. Alternative procedures are outlined for instances where the initial mode of therapy does not produce the anticipated results.

21—BACTERIOLOGIC SURVEY OF A BLOOD BANK

Ned G. Maxwell, M. D., Milwaukee Blood Center, Inc.

The exhibit is a self-contained, four-panel series of photographs and written commentary on the bacteriologic aspects of obtaining and delivering blood. There will be a descriptive pamphlet describing the entire exhibit available for visitors to the exhibit.

47—ADENOMAS OF THE COLON

Thomas J. Foley, M.D., and Jack Selzer, M.D., Milwaukee

A presentation of the microscopic, gross types of adenoma will be given along with their treatment and methods of diagnosis. A new method of surgical diagnosis of polyps will be demonstrated.

48—ELECTROCARDIOGRAPHY

George A. Hellmuth, M. D., Milwaukee, and the Wisconsin Heart Association

48a—FIBRINOGENOPENIA:

E. S. Olson, M. D., St. Luke's Memorial Hospital, Racine

Charts outlining the pathogenesis, diagnosis, and treatment of fibrinogenopenia are presented, including seven case reports with photographs.

Acquired fibrinogenopenia is mainly discussed since it is seen more frequently than the congenital form. However, patients with hemorrhage may have a congenital or an acquired fibrinogenopenia and both must be considered. The acquired state is not too uncommon and may be associated with blood dyscrasias and liver conditions. There may also be an increased utilization of fibrinogen secondary to the absorption of thromboplastin or the activation of plasminogen. These mechanisms will reduce the fibrinogen content of the blood. The conditions in which this may occur, along with various mechanisms, are discussed.

When fibrinogenopenia is suspected, it should be confirmed by a fibrinogen determination or by observing the clotting of the blood. Hemophilia can be ruled out in these hemorrhagic states as a firm clot is formed in this condition.

Management of these cases includes prophylactic and active measures. Details are discussed

49—NEW TECHNIQUES in CARDIAC DIAGNOSIS AND SURGICAL TREATMENT OF SHOCK

Cardiovascular Laboratory, University of Wisconsin Medical School

Instruments and catheters utilized in left and right heart catheterization will be displayed, as will normal patterns of pressure in the cardiac chambers and large vessels. Abnormal pressure patterns associated with congenital and acquired heart disease will be depicted by display of the pressure records. Correlation of the clinical signs with the physiologic measurements will be accomplished in the more common acquired and congenital disorders of the heart. Technique of diagnostic dye dilution curves will be shown.

Instruments and equipment utilized for the surgical correction of acquired and congenital heart disease will be displayed.

50—OPERATION HEART

S. L. Burchman, M. D., Department of Anesthesiology, and W. P. Young, M. D., Department of Surgery, University of Wisconsin Medical School

The position and accomplishments of cardiovascular surgery today are the result of a highly coordinated team effort. This audio-visual presentation depicts the role of one member of that team—the Department of Anesthesiology of the University of Wisconsin Hospitals.

75—AUTOPLASTIC CUTIS VASCULAR GRAFT

Marvin Wagner, M. D., H. B. Benjamin, M. D., Joseph Kuzma, M. D., and Walter Zeit, Ph.D., Marquette University School of Medicine

This exhibit is based upon a three-year period of experimentation in dogs with major vascular replacements, using nylon, formalin-treated nylon crimped tube, and "autoplastic-cutis-vascular tubes"; the latter were found to be an ideal blood vessel replacement. The work has been applied with success in five human operations.

The exhibit demonstrates a method of constructing a vascular prosthesis from skin, illustrated by photographs and mounted specimens, as well as case histories of human applications.

76—VASCULAR ARCHITECTURE OF THE SMALL INTESTINE

Allen Becker, M. D., and H. B. Benjamin ,M. D., Marquette University School of Medicine

This demonstration deals with a new concept of the vascular pattern of the small intestine and how it affects the surgery of this organ. The old concept will be shown along with the new concept as demonstrated by recent vascular research in this field. Transparencies with appropriate legends describing the films as well as drawings of the problem will be on display.

76a—HEALTH APPRAISAL OF THE SCHOOL CHILD

American Medical Association and the Division on School Health of the State Medical Society of Wisconsin

A presentation of the procedures involved by school personnel and physicians in making an appraisal of the school child. Principal steps emphasized are teacher observation, screening procedures, dental examination, medical examination, and follow-through by teachers, family, and physicians. A combined visual and auditory presentation is made of the essential steps involved in the examination of a school child.

76b—(facing stage): NEWER METHODS IN NEUROSURGERY

Henry M. Suckle, M. D., Madison

The exhibit will display newer methods in neurosurgical treatment. The treatment of Parkinsonism by chemopallidectomy will be demonstrated, showing instruments, and localization of brain lesions necessary to relieve tremor and rigidity.

Hydrocephalus treatment, using valve techniques with special catheters from the brain to the internal jugular vein and heart, will be displayed and described. This method is valuable in that the change of the tube is rarely necessary, and there is preservation of the fluid and the electrolyte balance as the fluid is drained from the ventricle into the vascular system.

Localization of brain tumors with radioactive isotopes will be described and pictured. This presents a painless method of localization. The amount of isotopes necessary has no harmful effect on the body generally, and this can be done as an outpatient procedure.

95—TUBERCULIN TESTING

A. A. Pleyte, M. D., Wisconsin Anti-Tuberculosis Association

The importance of tuberculin testing in reference to detection of tuberculosis is emphasized in the exhibit. Its value in finding unknown cases, as a significant test in differential diagnosis, as a clue to the case that infected the reactor, and as a tool in social research are points emphasized. With the development of new drugs and emphasis upon controlled ambulatory care, importance of the skin testing program and its rightful place in an effective state program of detection and treatment makes this exhibit of special educational value to Wisconsin physicians.

REMEMBER . . .

Be sure to attend at least one session of the House of Delegates: Monday evening at 7:30 p.m., Tuesday at 7:30 p.m. or Wednesday at 9:00 a.m.

★

Be sure to attend the President's Reception in the East Room, Hotel Schroeder, 6:15 p.m., Wednesday evening. All State Medical Society members and their ladies are invited. The reception will honor the completion of Dr. H. E. Kasten's term as president of the society.

★

You'll find something new and valuable in the Scientific and Technical Exhibits. Don't miss them.

96—WISCONSIN CAMPS FOR DIABETIC CHILDREN

Committee on Diabetes of the State Medical Society of Wisconsin and Wisconsin Diabetes Association

The exhibit will depict by way of literature, posters and motion picture the objectives and accomplishments of summer camps for Wisconsin boys and girls with diabetes.

101—THERAPEUTIC EXERCISE IN POSTURAL LOW BACK PAIN

Albert M. Cohen, M. D., Milwaukee, for the Division on Rehabilitation, State Medical Society; VA Medical Center, Milwaukee, and Marquette University School of Medicine

A demonstration by charts and illustrations of the relationship between poor posture and low back pain and the properly applied therapeutic exercises that will correct the underlying cause. Charts illustrate the abnormal skeletal alignment found in poor posture and the resulting muscle imbalance as compared to normal skeletal alignment and normal muscle balance in good posture. The employment of proper postural principles in various activities of daily living both for prevention and correction of poor postural alignment is presented.

102—ACUTE ABDOMINAL TRAUMA

E. A. Bachhuber, M. D., and J. D. Hurley, M. D., Milwaukee County Hospital

The exhibit will outline steps in diagnosis and management of acute abdominal trauma, by means of placards, Kodachrome slides, and view boxes, to demonstrate pertinent x-ray aids.

103—STAFF OF ST. JOSEPH'S HOSPITAL, MILWAUKEE

Drs. G. Sengpiel, J. Wepfer, J. Klieger, and Mr. A. Bews, Milwaukee

This exhibit will feature the following research studies conducted by members of the hospital's medical staff:

1. Fetal and Neonatal Radiography
2. Adrenal Cortical Hyperplasia as a Cause of Amenorrhea
3. Clinical Use of Isotopes

104—CANCER REGISTRY AT ST. JOSEPH'S HOSPITAL, MILWAUKEE

Cancer Committee of St. Joseph's Hospital, Milwaukee

The exhibit will review experience of the Cancer Registry and equipment used. Members of the committee at the hospital will be in attendance to explain the mechanics of the registry, and to assist any physicians interested in providing a similar service in their local hospital.

105—The Treatment of the Traumatic Face

Drs. C. R. Dix, Paul Natvig and D. J. Carlson, Milwaukee Hospital

The care of the injured face can be considered as that required for soft tissues and for underlying framework of bone and cartilage. The soft tissue treatment is urgent to insure rapid healing and to keep down attendant scarring. Treatment of fractures can be deferred until satisfactory roentgenograms are available, and patient's general condition permits. Pictures will show various acute injuries with treatment. X-rays and drawings will demonstrate deep defects and correction methods.

106—DEACONESS HOSPITAL, MILWAUKEE

Medical Staff, Deaconess Hospital, Milwaukee

Part I:
Title: Cobalt 60 Teletherapy

Authors: Drs. A. Melamed, A. Marck, and A. H. Holt, Department of Radiology, Deaconess Hospital, Milwaukee

Description: The exhibit will present a summary of experience in use of this modality of radiation therapy in approximately 400 patients during the past two years. Indications, advantages and disadvantages, and effectiveness of Cobalt 60 Teletherapy will be presented.

Part II:
Title: Miniature Renogram

Authors: Drs. C. R. Marquardt, J. Pick, and A. Melamed, Section of Urology, Department of Radiology, Deaconess Hospital, Milwaukee

Description: X-ray film encased in plastic material of wafer thickness is readily sterilizable in solution and adaptable for renal stone surgery. This film molds easily to the kidney and its near routine use during surgery reduces the incidence of pseudo-recurrence, lessens time used in the search for stones, and provides absolute evidence of removal.

108—GROSS TISSUE DEMONSTRATION

Section on Pathology, and the Wisconsin Society of Pathologists

Members of the society will again conduct daily demonstrations of surgical and autopsy tissues.

109—CAUSES OF MATERNAL DEATHS IN WISCONSIN

F. J. Hofmeister, M. D., Milwaukee, for the Study Committee of the Wisconsin Maternal Mortaliy Survey of the State Medical Society of Wisconsin

An exhibit prepared by the Division of Maternal and Child Welfare demonstrates the principal causes of maternal deaths in Wisconsin and indicates statistically the trend of maternal deaths in this area.

110—IRON DEFICIENCY ANEMIA IN INFANTS AND CHILDREN

William H. Bartlett, M. D., Madison

This is an exhibit demonstrating a new mode of therapy—intramuscular iron—based upon a clinical study of 100 cases treated at Children's Hospital, Denver, 1956–1957, through the use of *Inferon*. The case studies are summarized in the form of charts and an accompanying brochure.

111—TUMORS, TRAUMATIC AND DEVELOPMENTAL DEFECTS OF THE NOSE

William H. Frackelton, M. D., and Jack L. Teasley, M. D., Milwaukee Children's Hospital and Marquette University School of Medicine

The nose is subject to the same frailities as all human flesh. It is frequently the site of primary skin cancer and subject to invasion by direct extension of cancer from adjacent structures. Illustrative cases of the treatment of small and more extensive carcinomas of the nose and reconstruction of the surgical defects will be presented.

The prominent position of the nose renders it particularly susceptible to trauma. Examples of acute traumatic conditions and their repair will be presented, as will examples of reconstruction of old traumatic deformities.

Developmental defects are varied. Some examples of these developmental anomalies will be presented. Frequently, the nasal deformity is part of a complex such as the cleft lip, jaw and palate defect. Examples of surgical reconstruction of these defects will be presented.

112—SURGICAL TREATMENT OF PROGNATHISM

Frank Bernard, M. D., and Gordon Davenport, M. D., Department of Surgery, U. of W. Medical School

The surgical correction of protrusion of the lower jaw will be presented. A series of cases will demonstrate the functional and cosmetic improvement gained through combined cooperative efforts of the plastic surgeon and orthodontist. Kodachrome transparencies will show progress from initial examination to final postoperative result.

113–114—EARLY NASAL INJURIES: A FACTOR IN FACIAL AND DENTAL DEFORMITY

M. H. Cottle, M. D., Chicago; L. E. Gaynon, M. D., and Charles Finn, M. D., Milwaukee

Prenatal, natal, and early childhood injuries to the nose occur very often. Dislocations, slight fractures, and other traumas may influence the quantitative and qualitative development of the premaxillae, maxilla, and nasal septum elements, producing facial asummetries, sagital and dental malalignments, and malocclusions. The anatomy of the premaxilla and its related structures and some related anthropological and comparative anatomy considerations are also presented to emphasize vulnerability of structures to change from external forces.

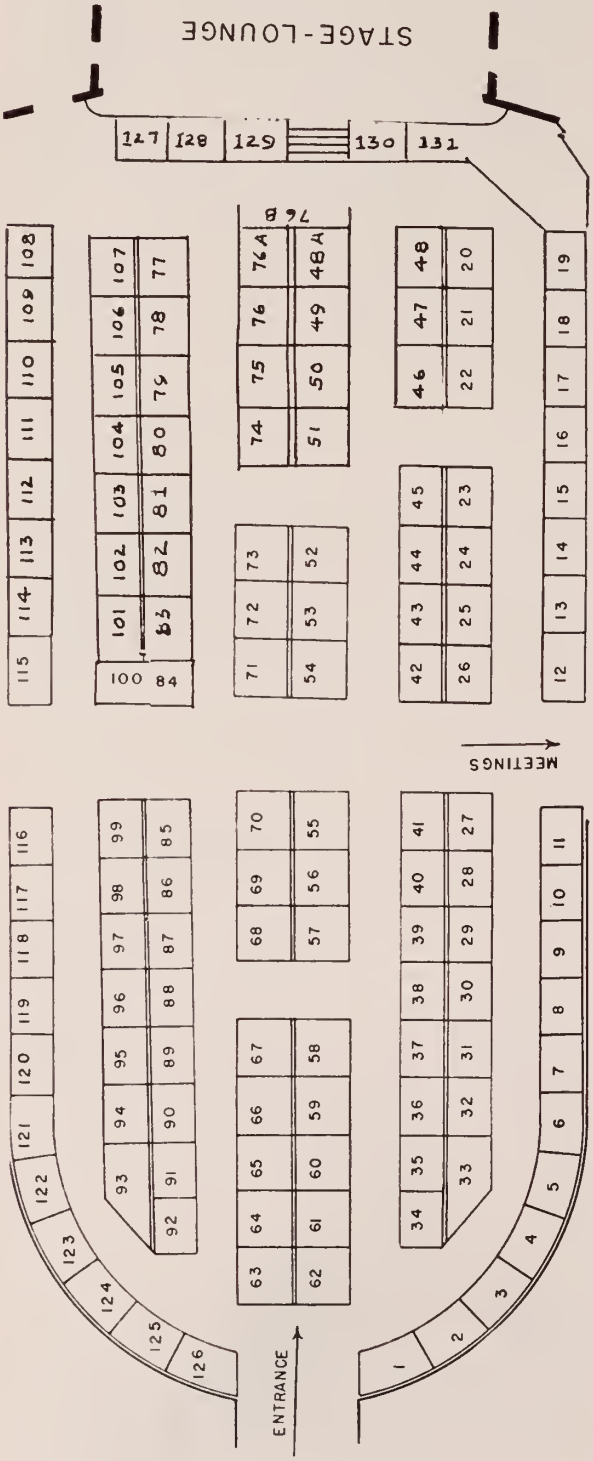
REGISTER, PLEASE . . .

Without the support of the Exhibitors, this meeting could not be made possible, unless a registration fee was charged each physician attending.

The Exhibit Representative can only judge the value of his exhibit in terms of physicians who stop and *register*. To encourage continued support of our Annual Meeting, we will appreciate your cooperation in making a special effort to register at many of the Exhibits whose products you use or wish to consider in your practice.

H. E. KASTEN, M.D.
President

EXHIBIT LOCATIONS:



HOSTS FOR GUEST SPEAKERS

SPEAKER	MILWAUKEE HOST
HOWARD L. ALT, M.D.	ANTHONY V. PISCIOTTA, M.D.
VIRGINIA APGAR, M.D.	ANNE E. ROETHKE, M.D.
EARL E. BARTH, M.D.	J. L. ARMBRUSTER, M.D.
LOUIS A. BRUNSTING, M.D.	M. J. REUTER, M.D.
BURRILL B. CROHN, M.D.	MICHAEL W. SHUTKIN, M.D.
ANTHONY J. DE PALMA, M.D.	BRUCE J. BREWER, M.D.
JOHN S. DE TAR, M.D.	JOSEPH S. DEVITT, M.D.
C. ALLEN GOOD, M.D.	ROBERT W. BYRNES, M.D.
HAROLD R. GRIFFITH, M.D.	RICHARD FOREGGER, M.D.
ANCEL KEYS, PH.D.	PAUL G. LA BISSONIERE, M.D.
JOHN C. MACQUEEN, M.D.	JEAN P. DAVIS, M.D.
FRANKLIN L. PAYNE, M.D.	JACKSON F. STODDARD, M.D.
ROBERT D. PILLSBURY, LT. COL.	LEO R. WEINSHEL, M.D.
BRUCE PROCTOR, M.D.	RALPH T. RANK, M.D.
RALPH RABINOVITCH, M.D.	EDWARD C. SCHMIDT, M.D.
MARK RAVITCH, M.D.	WALTON D. THOMAS, M.D.
JAMES W. REAGAN, M.D.	DAN B. CLAUDON, M.D.
HOWARD ROOT, M.D.	BRUNO J. PETERS, M.D.
A. D. RUEDEMANN, M.D.	HERBERT G. SCHMIDT, M.D.
RICHARD H. SEGNITZ, M.D.	DAVID W. OVITT, M.D.
FRANK R. SMITH, M.D.	ALICE D. WATTS, M.D.
JAMES K. STACK, M.D.	PAUL J. COLLOPY, M.D.
VINCENT J. VAUGHN, M.D.	J. C. DEVINE, M.D.
J. W. WILCE, M.D.	CHARLES R. EICHENBERGER, M.D.

WISCONSIN ASSOCIATION OF BLOOD BANKS

ANNUAL MEETING

May 3, Ambassador Hotel, Milwaukee

Speakers: Robert Suerth, Wisconsin Rapids; Elsa B. Edelman, M.D., Milwaukee; Marie Koch, M.D., Wood; E. S. Olson, M.D., Racine; Ned G. Maxwell, M.D., Milwaukee; Joseph D. Boggs, M.D., Chicago and Fred Madison, M.D., Milwaukee

Subjects: Progress in Accreditation, Bacteriologic Problems, Reduction of Hepatitis, Screening by Laboratory Tests for Silent Hepatitis Carriers, Special Blood Bank Preparations, and Use and Abuse of Blood.

9:00 a.m.—Registration and Program.
12:15 p.m.—Luncheon, Ambassador Hotel, 2306 W. Wisconsin Ave.
2:00 p.m.—Scientific Program
6:00 p.m.—Cocktails
6:30 p.m.—Dinner and Business Meeting, Entertainment

* * *

Luncheon ($1.75), Dinner ($3.75). Send reservations to Mr. James Fosshage, Box 603, Madison 1, Wisconsin.

EXHIBITS AT FOOT OF STAGE

130—EXFOLIATIVE CYTOLOGY IN THE DIAGNOSIS OF EARLY CANCER

American Cancer Society, through the Wisconsin and Milwaukee Divisions

This exhibit received its premiere showing at the American Medical Association in June, 1955, in Atlantic City. It outlines the historical development of the smear technique, methods of procuring smears, and their preparation from several sites—uterus, lung, stomach, urinary tract, and colon and rectum—together with representative smears from each and reported accuracy from several clinics. A panel is devoted to investigative aspects of the problem and which includes Dr. Papanicolaou's work on breast smears, Graham's study of the SR reaction, results of mass screening studies—the Shelby County project, the Draghi tampon, the self-obtained smears, and an outline of the current status of the cytonanalyzer.

131—BIOPSY TECHNIQUES IN CARCINOMA IN SITU

William D. Stovall, M. D., Director, Laboratory of Hygiene, State Board of Health and University of Wisconsin Medical School, Madison

This exhibit will discuss in pictorial and legend form carcinoma in situ of the uterine cervix and presents the problem of its diagnosis and treatment arising out of the cytologic examination of smears. Since the recognition of this lesion is often not possible by any other method, and since the result is not definitive, it raises problems in diagnosis affecting the general practitioner, the surgeon and the pathologist. Presentation of these problems is the purpose of this exhibit.

EXHIBITS ON THE STAGE

BLUE SHIELD IN WISCONSIN

Representatives will be available to answer questions and provide information about claims, coverage and enrollment. Visit our booth on the stage!

WISCONSIN STATE MEDICAL ASSISTANTS' SOCIETY

Officers of the society will be on hand to explain services and functions of the organization, and to distribute pamphlets telling about its placement service. Welcome, Doctors!

DOCTOR!

If you haven't already done so, we urge you to send in your reservations for Round-Table Luncheons and the Annual Meeting Dinner.

The Dinner was moved up to Wednesday evening this year, to make it easier for you to attend. It promises to be a gala night, so plan to be with us!

RESERVATIONS

Participation in all these important functions is limited. . thus it is essential you make your reservations at once.

Don't delay . . . MAIL TODAY!

ROUND TABLES — LIST 3 CHOICES

EACH DAY YOU WILL ATTEND

$2.50 each — MAKE CHECK PAYABLE TO: STATE MEDICAL SOCIETY OF WISCONSIN

Leader's Name

■ **TUESDAY, MAY 6:**

First Choice: _____

Second Choice: _____

Third Choice: _____

■ **WEDNESDAY, MAY 7:**

First Choice: _____

Second Choice: _____

Third Choice: _____

■ **THURSDAY, MAY 8:**

First Choice: _____

Second Choice: _____

Third Choice: _____

ANNUAL DINNER: WEDNESDAY MAY 7

Big event of Annual Meeting . . . Will feature music, professional entertainment and dancing. Don't miss this great program! As space is limited, advance reservations are essential.

$6.50 each — Includes President's Reception, Dinner, Floor Show, and Dance . . . . .

NUMBER ANNUAL DINNER TICKETS: _____

Total Amount of Your Check: $_____

Name: _____

Address: _____

City: _____

Mail to: STATE MEDICAL SOCIETY OF WISCONSIN
BOX 1109, MADISON 1, WISCONSIN

1958 Auxiliary Convention Program

THIRTY YEARS OF PARTNERSHIP

MRS. A. J. BAUMANN
Milwaukee

MRS. G. J. SCHULZ
Union Grove

Tuesday, May 6

P.M.

3:00 Registration, Main Lobby, Hotel Schroeder

6:30 Board of Directors' Dinner and Meeting
English Room, Hotel Schroeder
(Dress semiformal)
Those who attend: State Officers, State Chairmen, County Presidents and Presidents-Elect, Past State Presidents and Honored Guests

Wednesday, May 7

A.M.

8:30 to 9:45 Continental Breakfast
Loraine Room, Hotel Schroeder
Courtesy of the Woman's Auxiliary to the Racine County Medical Society

9:00 Registration, Fifth Floor, Hotel Schroeder

10:00 Formal Opening of the Thirtieth Annual Meeting of the Woman's Auxiliary to the State Medical Society of Wisconsin, Loraine Room, Hotel Schroeder
Mrs. A. J. Baumann, President, presiding
Invocation—Reverend A. H. Schmeuszer, Milwaukee, Administrator, Deaconess Hospital
Acceptance of Agenda
Pledge to Flag—Mrs. C. R. Pearson, Baraboo
Auxiliary Pledge—Mrs. C. R. Pearson
Introduction of Officers, Honored Guests, and Representatives of the Auxiliary to the Student A.M.A.
Address of Welcome—Mrs. W. E. Buckley, Racine
Response—Mrs. M. Q. Howard, Milwaukee
Convention Announcements — Mrs. J. G. Jamieson, Racine
Convention Rules of Order—Mrs. Leif Lokvam, Kenosha
Minutes of Twenty-Ninth Meeting — Mrs. G. A. Behnke, Kaukauna
Treasurer's Report — Mrs. S. H. Ambrose, Whitewater
Report of the President—Mrs. A. J. Baumann
Reports of State Chairman (time limit—2 minutes)
Reports of County Auxiliaries (time limit—2 minutes) by County Presidents or Representatives
Report on Registration—Mrs. Frank Scheible, Racine

P.M.

1:00 Spring Salad Luncheon
Milwaukee Athletic Club
In honor of Mrs. Frank Gastineau, Indianapolis, First Vice-President, Woman's Auxiliary to the American Medical Association, and Wisconsin Past State Presidents

MRS. RUTH GROSH
Glenview, Illinois

"The King and I"—a Musical Miniature by Mrs. Ruth Grosh, Glenview, Illinois

Awarding of Door Prizes

. . . Time to shop and visit the exhibits of the Auxiliary and the State Medical Society at the Auditorium

6:30 Reception of the President of the State Medical Society of Wisconsin
East Room, Hotel Schroeder

7:15 Annual Dinner, State Medical Society of Wisconsin
Crystal Ballroom, Hotel Schroeder

Thursday, May 8

A. M.

8:30 to 9:45 Continental Breakfast
Loraine Room, Hotel Schroeder
Courtesy of the Woman's Auxiliary to the Racine County Medical Society

9:00 Registration, Main Lobby, Hotel Schroeder

10:00 Business Session, Loraine Room, Hotel Schroeder
Mrs. A. J. Baumann, President, presiding

Convention Announcements — Mrs. W. E. Buckley, Racine

Memorial Service — Mrs. M. J. Reuter, Milwaukee

Report of the Nominating Committee—Mrs. H. W. Christensen, Wausau

Election of Officers

Installation of Officers—Mrs. Frank Gastineau, First Vice-President of the Woman's Auxiliary to the American Medical Association

Presentation of President's Pin—Mrs. R. M. Kurten, Racine

Inaugural Address—Mrs. G. J. Schulz, Union Grove

Final Report on Registration—Mrs. Frank Scheible

11:30 Post-Convention Planning Meeting, Loraine Room, Hotel Schroeder
Mrs. G. J. Schulz, President, presiding

P.M.

1:00 Spring Buffet Luncheon
Memorial Center Auditorium

In Honor of County Auxiliary Presidents, Officers, and Chairmen

"Village Wooing"—a three-act comedy written by George Bernard Shaw
The First Drama Trio of Wisconsin

Awarding of Door Prizes

. . . Time to shop and visit the exhibits of the Auxiliary and the State Medical Society at the Auditorium

—Milwaukee Sentinel

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Left to right: Ruth Hinn Swaziek, David MacArthur, Jeanne Mueller Helminiak.

Convention Hostesses

MEMBERS OF THE WOMAN'S AUXILIARY TO THE RACINE COUNTY MEDICAL SOCIETY

Front row, left to right: Mrs. Frank Scheible, registration; Mrs. William Donnell, convention hall; Mrs. William Henken, Wednesday luncheon; Mrs. Frank Hilpert, tickets; Mrs. C. R. Newman, Thursday luncheon.

Back row: Mrs. K. W. Covell, breakfasts; Mrs. J. D. Postorino, publicity; Mrs. Marvin Nelson, information desk; Mrs. John G. Jamieson, general chairman; Mrs. William Buckley, co-chairman; Mrs. Harry Ageloff, flowers; Mrs. James Cook, convention treasurer.

Not shown in the picture: Mrs. Louis E. Fazen, Jr., Board of Directors' dinner.

THE TECHNICAL EXHIBITS . . .

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117—Audio-Digest Foundation, Glendale, Calif.
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1—General Electric Co., Milwaukee
28—Gerber Products Co., Fremont, Mich.
45—Hermien Nusbaum and Associates, Chicago
10—H. G. Fischer and Co., Franklin Park, Ill.
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61—J. B. Roerig and Co., New York
119—John Nichols Inc., Milwaukee
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8-9—Lakeside Laboratories, Inc., Milwaukee
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29—Noll Pharmaceutical Co., Orange, N. J.
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46—Orthopedic Appliance Co. Inc., Milwaukee
35—Pet Milk Co., St. Louis
125—Pfizer Laboratories Inc., Brooklyn
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13—Professional Office Building Inc., Madison
90—Purdue Frederick Co., New York
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123-124—Roemer-Karrer Co., Milwaukee
71—Ross Laboratories, Columbus, O.
52—Sanborn Co., Waltham, Mass.
57—Sandoz Pharmaceuticals, Hanover, N. J.
11—Schering Corp., Bloomfield, N. J.
69—S. E. Massengill Co., Bristol, Tenn.
77-7—Up Develops' Association of Wisconsin Inc., Milwaukee
25—S. J. Tutag and Co., Detroit
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5—Smith, Kline and French Laboratories, Philadelphia
128—Stuart Co., Chicago
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7—U. S. Vitamin Corp., New York
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24—Warner-Chilcott Laboratories, Morris Plains, N. J.
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120—Wyeta Laboratories, Philadelphia
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DEAR DOCTOR:

The fourth annual meeting of the Wisconsin State Medical Assistants Society will be held June 7–8 at the Schwartz Hotel, Elkhart Lake.

We will be very grateful to you, Doctor, if you will encourage your medical assistants to attend.

We have a very fine program planned, including a talk on "Small Town Practice." I am sure it will greatly benefit girls from one-doctor offices in smaller communities. Wisconsin Physicians Service will be explained and discussed with us, and there will be other interesting, informative presentations.

The Wisconsin Medical Assistants Society was created four years ago to provide and stimulate educational services for its members, and to encourage a feeling of fellowship and cooperation among its members.

Even if your medical assistant is not now a member, she may attend. The requirement is that she be employed by, or work under the direct supervision of, a doctor of medicine who is a member in good standing of the State Medical Society.

Your assistant will come back from our annual meeting a better employee, better informed and with more desire than ever to be a loyal helpmate in medicine.

As in 1956 and 1957, the Wisconsin State Medical Assistants Society will have a booth at the Annual Meeting of the State Medical Society in Milwaukee, May 6–8. We would be most happy to have you stop by, and to make inquiries about our objectives and projects. You will be a most welcome guest.

Sincerely,

AUDREY HOLTSHOPPLE
President

115 South Main Street
Janesville, Wisconsin

"Wake in our breast the living fires,
The Holy faith that warmed our sires. . . ."
OLIVER WENDELL HOLMES, M. D.

. . . gleanings from the Section on Medical History

Perhaps some reader of this page can help establish the name of the first physician in the Black River Falls–Hixton area in Northwestern Wisconsin. At the moment, there is some question.

One resident of Trempealeau County contends that Dr. Joel Negness arrived before the Civil War and tended the whites and Indians in the area. He also recalls Dr. William Wilson, "who walked four miles in a snowstorm to attend my mother when I was born in 1867."

Physicians of that era, he said, doctored with herbs. He recalls wearing a bag of "fetty" (asafetida) around his neck as a youth.

Another historian, a near neighbor, says, "No Norwegian, such as Dr. Negness must have been, would have dared to come here in the early settlement because our forefathers were state of Mainers and New Yorkers. Drs. Baxter and Cole were the first, I'm sure."

Mention also was made of a Dr. Frank Powell who, under the name of White Beaver, served the area Indians as a medicine man.

Information about the first practitioners in Trempealeau County is sought, as is information about the first physicians in any section of Wisconsin. You are invited to send it to Section on Medical History, State Medical Society, Box 1109, Madison 1.

* * *

Have *you* made arrangements for your contribution to the Medical Museum of Wisconsin? Will you be one of the doctors who will say, "I'm mighty proud of having had a part in making this museum possible."? This is a *once-in-a-lifetime* project, one that is most worth while and significant. The museum will be the only one of its kind in this country, and be a fitting memorial to the great physicians who have written—and who are now writing—the great story of medical progress in Wisconsin.

* * *

Dr. A. F. Haag, of Eau Claire, sent the Section on Medical History a quack gadget at least 100 years old. It had been given to him by a patient who had the instrument in her family before the Civil War.

The gadget was circulated from neighbor to neighbor for the alleged treatment of all pains and illnesses, from a toothache to yellow fever.

Its operation was based on the old fashioned cupping method, aimed at producing laudable pus, which was believed to remove poisons causing disease.

The technique was to remove the cap from the instrument, apply an oil (probably croton oil), then apply the gadget over the affected parts of the human anatomy, and finally work a plunger up and down. This punctured the skin. Several days later the pus appeared.

Doctor Haag's patient said members of her family, fearing the treatment, would not make known their ailments. The treatment, she said, was much more painful and uncomfortable than the disease itself.

* * *

Recent contributions:

From Dr. Jerome Head, Chicago, and Mrs. Thomas Coleman, Madison, papers of their father, Dr. Louis Head, Madison, who died in 1933. The late Doctor Head was a contract physician for The Milwaukee Road.

From Dr. L. T. Kent, Kenosha, a skeleton and an assortment of surgical instruments of ancient vintage.

From Miss Katherine Martindale, La Crosse, an incense lamp-type vaporizer (dated 1870) used for diphtheria, asthma, and whooping cough.

From Dr. I. E. Schiek, Rhinelander, a two-hour tape on medical history of his area.

From Hardware Mutual Casualty Company, files on The Wisconsin Plan of medical insurance. These were microfilmed and returned.

From the estate of Dr. Louis E. Schmidt, Wausau, who died in 1957, letters, documents, and papers.

the Wisconsin Medical Journal

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References: (1) Greenblatt, R. B., & Clark, S. L.: M. Clin. North America, Philadelphia, W. B. Saunders Company (Mar.) 1957, p. 587. (2) Greenblatt, R. B.: *J. Clin. Endocrinol.* *16*:869, 1956. (3) Hertz, R.; Waite, J. H., & Thomas, L. B.: *Proc. Soc. Exper. Biol. & Med.* *91*:418, 1956.

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Volume 57
Number 4

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FILMSTRIP 2 Part I *The Hands in Arthritis and Related Conditions* • Darrell C. Crain (Washington, D. C.) • Certificate of Merit • **Part II** *Intramuscular Iron for the Treatment of Iron Deficiency Anemia in Infancy* • Ralph O. Wallerstein, and M. Silvija Hoag (San Francisco)

FILMSTRIP 3 Part I *Bronchial Asthma* • John W. Irwin, Irving H. Itkin, Sandylee Weille and Nancy Little (Boston) • Honorable Mention Award • **Part II** *The Direct (Open) Surgical Repair of Congenital and Acquired Intracardiac Malformations* • C. W. Lillehei, H. E. Warden, R. A. DeWall, V. L. Gott, R. D. Sellers, M. Cohen, R. C. Read, R. L. Varco and O. H. Wangensteen (Minneapolis) • Hektoen Gold Medal for originality and excellence of presentation in an exhibit of original investigation

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references: 1. Strub, I. H.: Personal communication. 2. Ayd, F. J., Jr.: presented at Ohio Assembly of General Practice, 7th Annual Scientific Assembly, Columbus, September 18-19, 1957.

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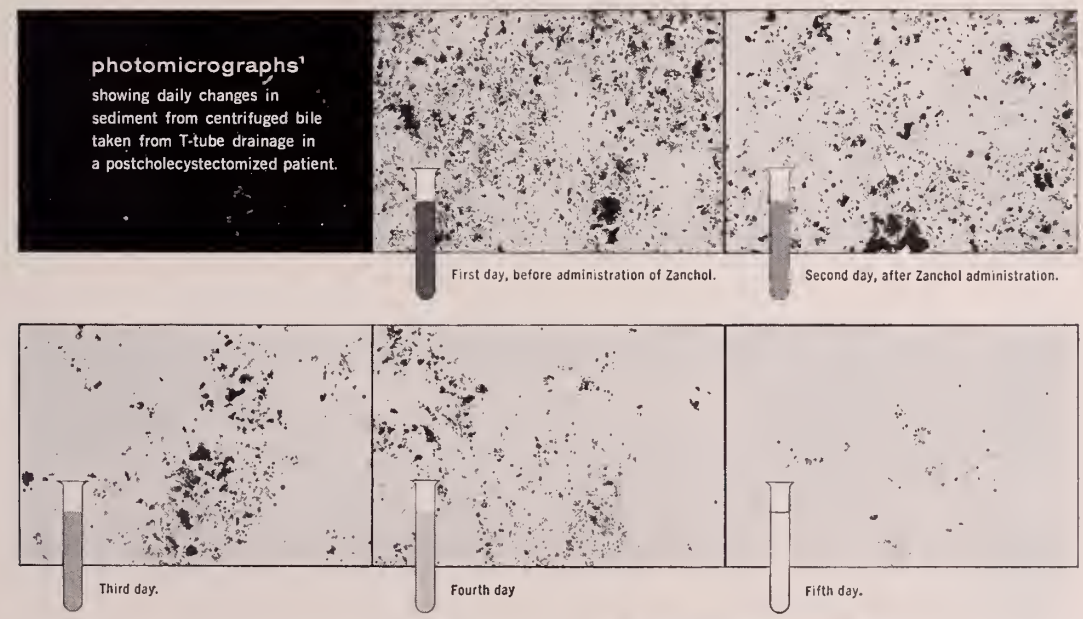

1. McGowan, J. M.: Clinical Significance of Changes in Common Duct Bile Resulting from a New Synthetic Choleretic, Surg., Gynec. & Obst. *103*:163 (Aug.) 1956.

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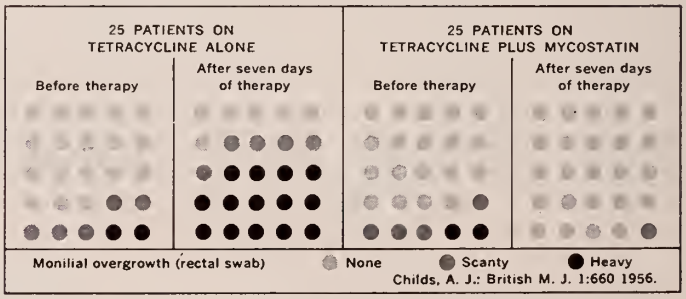

Childs, A. J.: British M. J. 1:660 1956.

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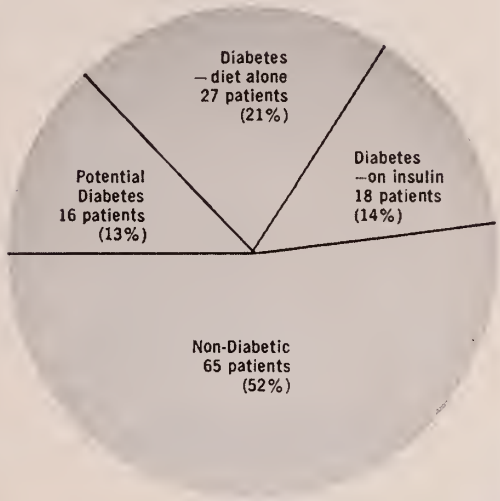

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*Murphy, R.: Connecticut M. J. *21*:306, 1957.

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Riseman, J. E. F., Altman, G. E., and Koretsky, S.: Nitroglycerin and Other Nitrites in the Treatment of Angina Pectoris, Circulation (Jan.) 1958.

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References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

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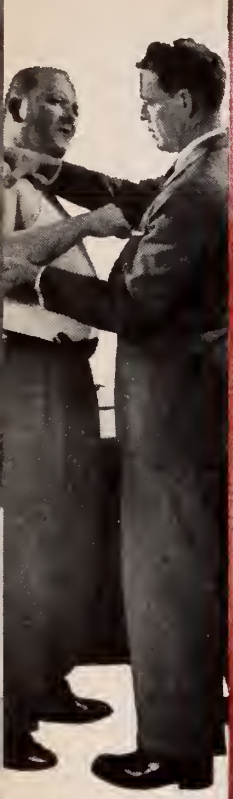
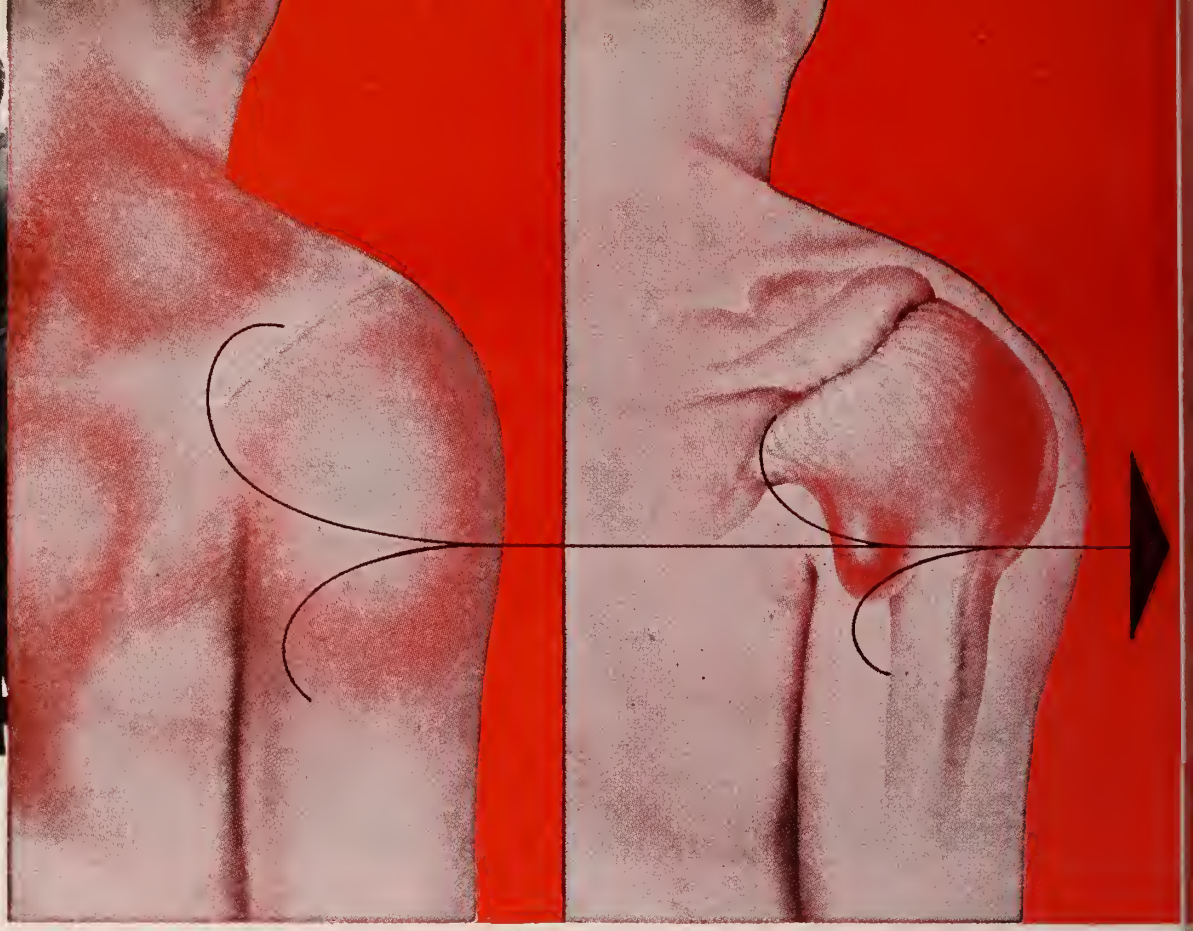
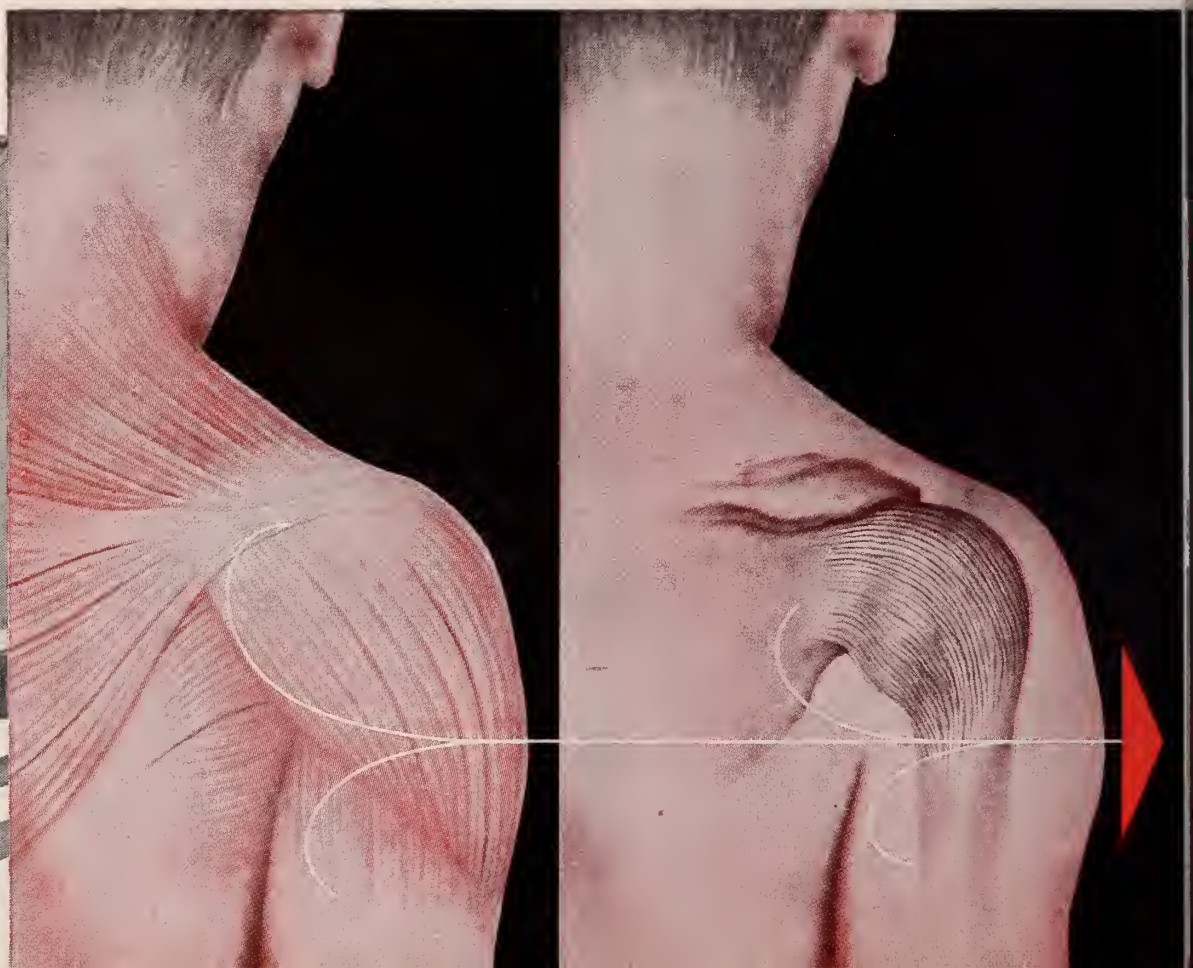




"Rheumatoid arthritis is a constitutional disease with symptoms affecting chiefly joints and muscles."[1] "Pain in the affected joint is accompanied by splinting of the adjacent muscles, with resultant 'muscle spasm.' "[2]



rheumatoid arthritis involves both joints and muscles

only

MEPROLONE®

THE FIRST MEPROBAMATE PREDNISOLONE THERAPY

meprobamate to relieve muscle spasm
prednisolone to suppress inflammation

relieves both muscle spasm and joint inflammation

MEPROLONE is the only anti-rheumatic-antiarthritic designed to relieve simultaneously (a) muscle spasm (b) joint-muscle inflammation (c) physical distress . . . and may thereby help prevent deformity and disability in more arthritic patients to a greater degree than ever before.

SUPPLIED: Multiple Compressed Tablets in two formulas:
MEPROLONE-2—2.0 mg. prednisolone, 200 mg. meprobamate and 200 mg. dried aluminum hydroxide gel (bottles of 100).
MEPROLONE-1—supplies 1.0 mg. prednisolone in the same formula as MEPROLONE-2 (bottles of 100).

1. Comroe's Arthritis: Hollander, J. L., p. 149 (Fifth Edition, Lea & Febiger, Philadelphia, Pa. 1953).
2. Merck Manual: Lyght, C. E., p. 1102 (Ninth Edition, Merck & Co., Inc., Rahway, N. J. 1956).

MSD MERCK SHARP & DOHME Philadelphia 1, Pa.
Division of MERCK & CO., INC.

in each of these indications for a tranquilizer...

SR is a cardiac patient. His doctor put him on ATARAX because (+) it is an anti-arrhythmic and non-hypotensive tranquilizer.

Other tranquilizers added to PN's g. i. discomfort (he has ulcers). But now his doctor has him on ATARAX because (+) it lowers gastric secretion while it tranquilizes.

Asthmatic JL used to have frequent tantrums followed by acute bronchospasm. Her family doctor tranquilized her with ATARAX because (+) it is safe, even for children.

Senile anxiety and persecution complex dogged Mrs. K. until her doctor prescribed ATARAX Syrup. (+) It tastes good, and it's a perfect vehicle for Mrs. K's tonic.

Dosage: Children, 1-2 *10 mg.* tablets or 1-2 tsp. Syrup t.i.d. Adults, one *25 mg.* tablet or 1 tbsp. Syrup q.i.d.

Supplied: 10, 25 and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

...ATARAX® (BRAND OF HYDROXYZINE) gives you an extra benefit

Rx ROERIG

New York 17, New York
Division, Chas. Pfizer & Co., Inc.

in G.I. disorders

'Compazine' controls tension —often brings complete relief

In such conditions as gastritis, pyloro-spasm, peptic ulcer and spastic colitis, 'Compazine' not only relieves anxiety and tension, but also controls the nausea and vomiting which often complicate these disorders.

Physicians who have used 'Compazine' in gastrointestinal disorders —often in chronic, unresponsive cases—have had gratifying results (87% favorable).

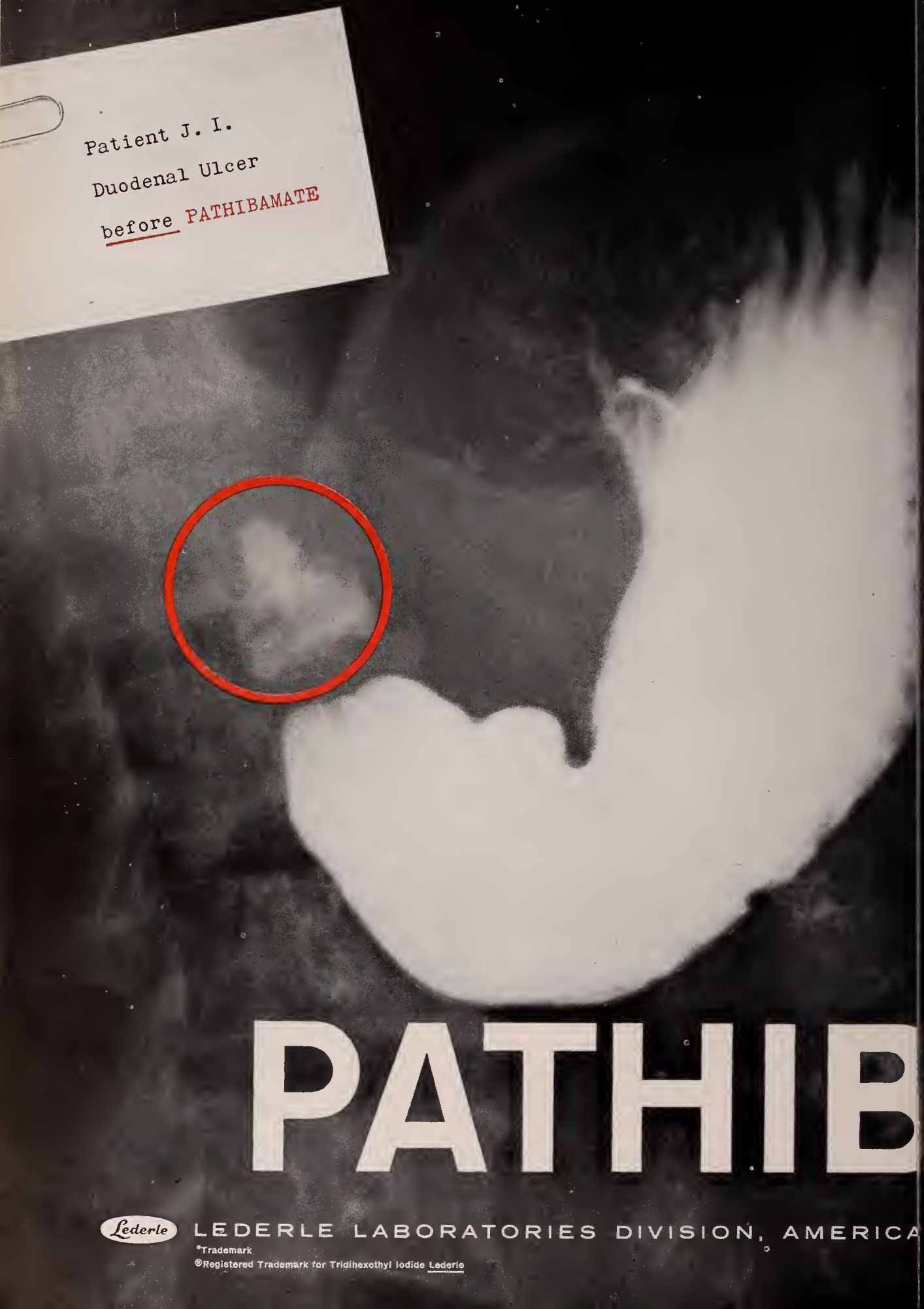
*Compazine**

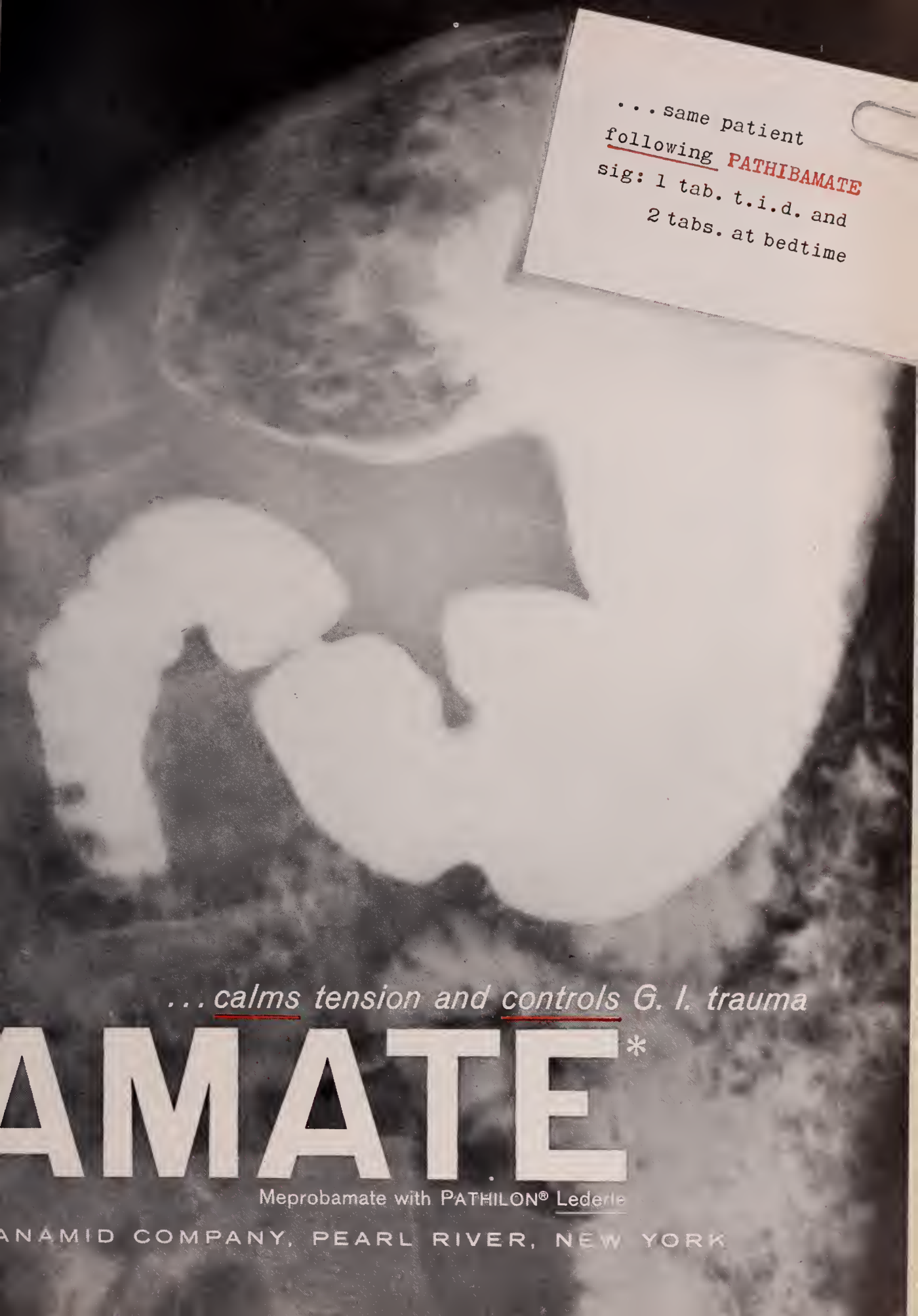
the tranquilizer and antiemetic remarkable for its freedom from drowsiness and depressing effect

Available: Tablets, Ampuls, Multiple dose vials, Spansule® sustained release capsules, Syrup and Suppositories.

*T.M. Reg. U.S. Pat. Off. for prochlorperazine, S.K.F.

Smith Kline & French Laboratories, Philadelphia


Patient J. I.
Duodenal Ulcer
before PATHIBAMATE
PATHIB
Lederle
LEDERLE LABORATORIES DIVISION, AMERICA
*Trademark
®Registered Trademark for Tridihexethyl Iodide Lederle


. . . same patient
following PATHIBAMATE
sig: 1 tab. t.i.d. and
2 tabs. at bedtime
. . . calms tension and controls G. I. trauma
AMATE*
Meprobamate with PATHILON® Lederle
ANAMID COMPANY, PEARL RIVER, NEW YORK

A MODERN PRIVATE SANITARIUM

for the Diagnosis, Care and Treatment of Nervous and Mental Disorders

MAIN BUILDING—One of 8 Units in "Cottage Plan"

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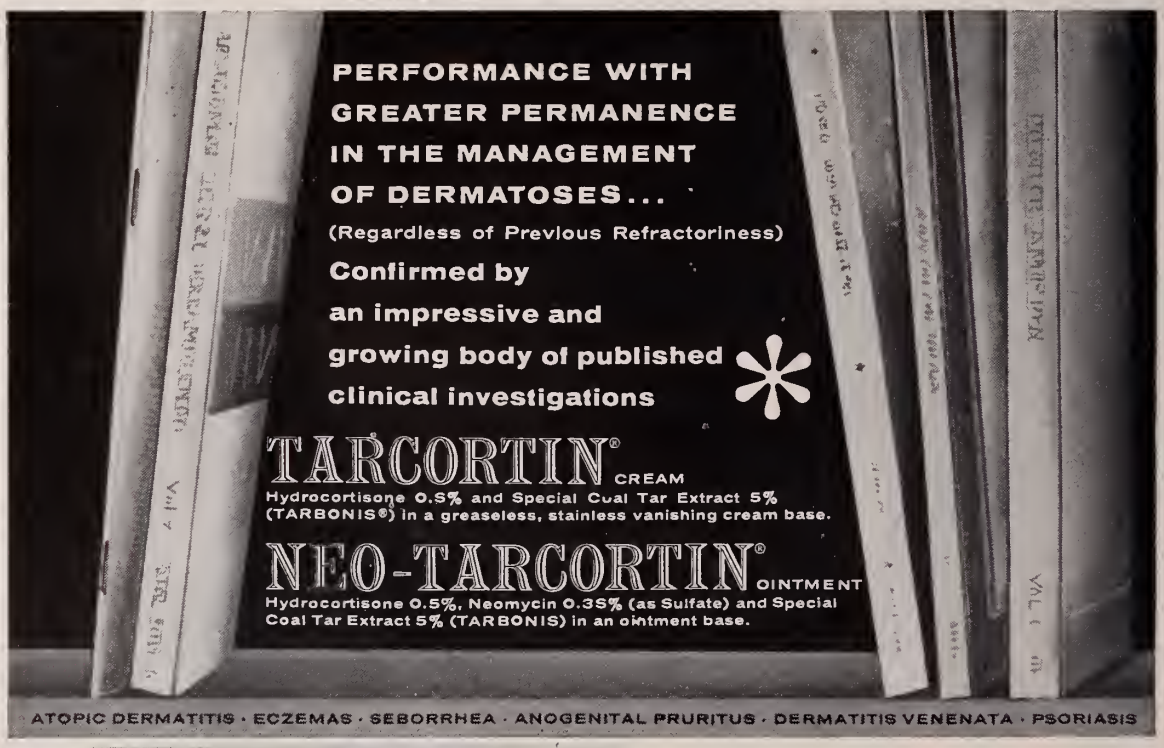

* J.A.M.A. *166*:158,1958; Welsh,A.L. and Ede,M. "*...prompt remissions of...acute phases.*" with TARCORTIN

R&C REED & CARNRICK / Jersey City 6, New Jersey

* 1. Clyman, S. G.: Postgrad. Med. *21*:309, 1957.
2. Bleiberg, J.: J. M. Soc. New Jersey *53*:37, 1956.
3. Abrams, B. P. and Shaw, C.: Clin. Med. *3*:839, 1956.
4. Welsh, A. L., and Ede, M.: Ohio State M. J. *50*:837, 1954.
5. Bleiberg, J.: Am. Practitioner *8*:1404, 1957.

IN ALL DIARRHEAS . . . REGARDLESS OF ETIOLOGY

comprehensive control with **CREMOMYCIN**®

SULFASUXIDINE* PECTIN-KAOLIN-NEOMYCIN SUSPENSION

SOOTHING ACTION . . . Kaolin and pectin coat and soothe the inflamed mucosa, adsorb toxins and help reduce intestinal hypermotility.

BROAD THERAPY . . . The combined antibacterial effectiveness of neomycin and Sulfasuxidine is concentrated in the bowel since the absorption of both agents is negligible.

LOCAL IRRITATION IS REDUCED and control is instituted against spread of infective organisms and loss of body fluid.

PALATABLE creamy pink, fruit-flavored CREMOMYCIN is pleasant tasting, readily accepted by patients of all ages.

*Sulfasuxidine is a trade-mark of Merck & Co., Inc.

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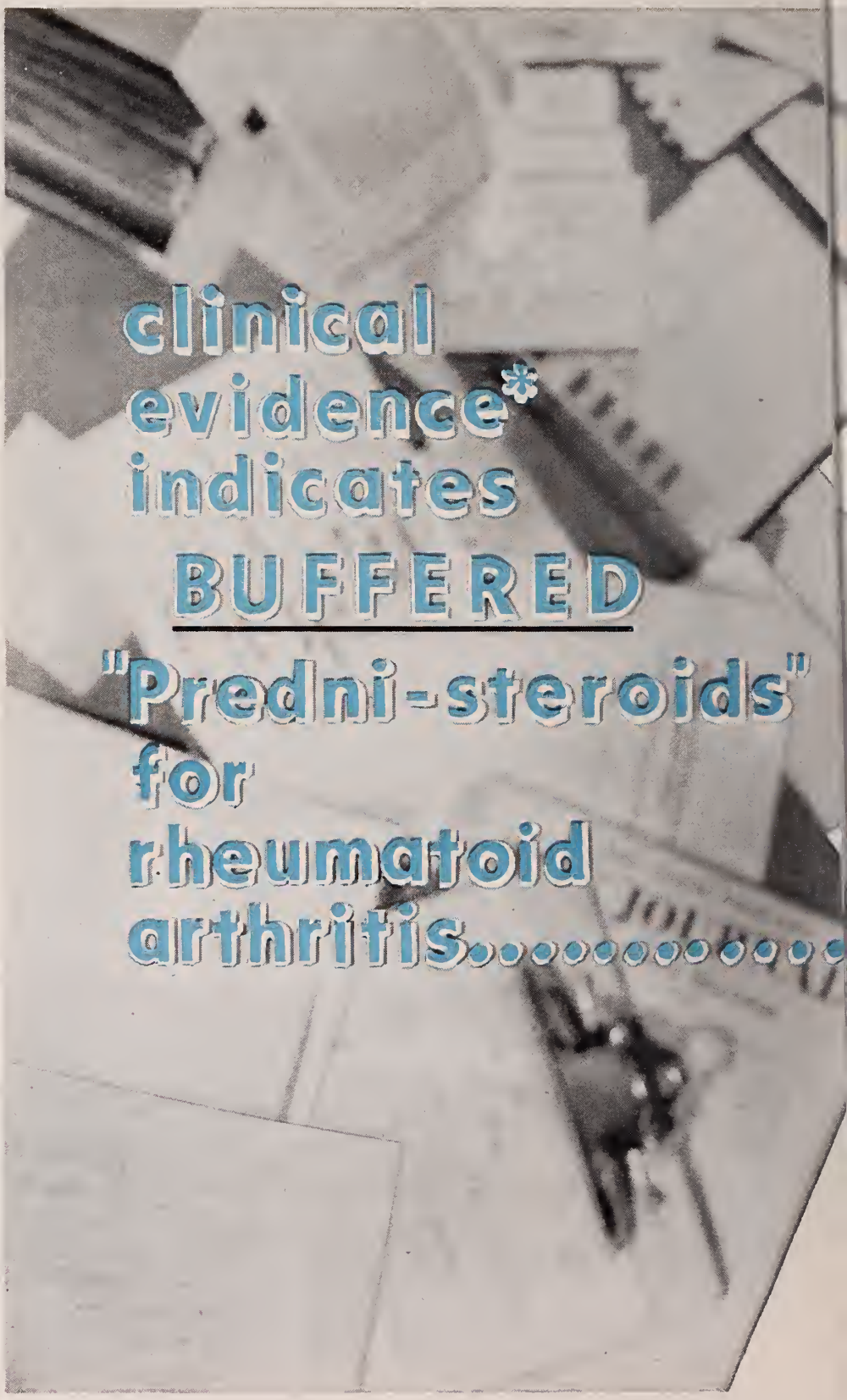
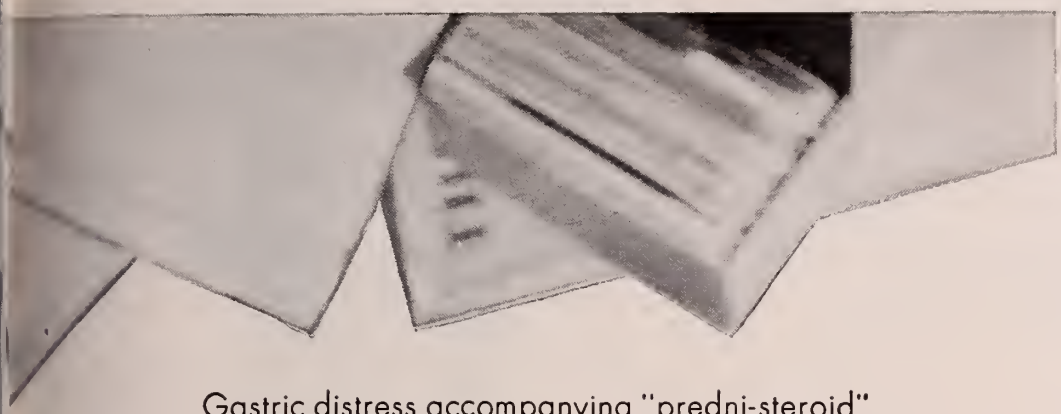

clinical
evidence*
indicates
BUFFERED
"Predni-steroids"
for
rheumatoid
arthritis.....



Gastric distress accompanying "predni-steroid" therapy is a definite clinical problem — well documented in a growing body of literature.

*"In view of the beneficial responses observed when antacids and bland diets were used concomitantly with prednisone and prednisolone, we feel that these measures should be employed prophylactically to offset any gastrointestinal side effects."—Dordick, J. R. *et al.*: N. Y. State J. Med. 57:2019 (June 15) 1957.

*"It is our growing conviction that all patients receiving oral steroids should take each dose after food or with adequate buffering with aluminum or magnesium hydroxide preparations."—Sigler, J. W. and Ensign, D. C.: J. Kentucky State M. A. 54:771 (Sept.) 1956.

*"The apparent high incidence of this serious [gastric] side effect in patients receiving prednisone or prednisolone suggests the advisability of routine co-administration of an aluminum hydroxide gel."—Bollet, A. J. and Bunim, J. J.: J. A. M. A. 158:459 (June 11) 1955.

One way to make sure that patients receive full benefits of "predni-steroid" therapy plus positive protection against gastric distress is by prescribing CO-DELTRA or CO-HYDELTRA.

Co-Deltra®

PREDNISONE BUFFERED

multiple compressed tablets

provide all the benefits of "Predni-steroid" therapy— plus positive antacid protection against gastric distress

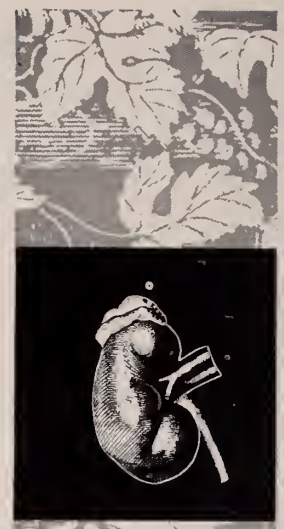
Co-Hydeltra®

PREDNISOLONE BUFFERED

2.5 mg. or 5.0 mg. of prednisone or prednisolone, plus 300 mg. of dried aluminum hydroxide gel and 50 mg. magnesium trisilicate, in bottles of 30, 100, 500.

MERCK SHARP & DOHME Division of MERCK & CO., INC., Philadelphia 1, Pa. MSD

why wine in Urology?



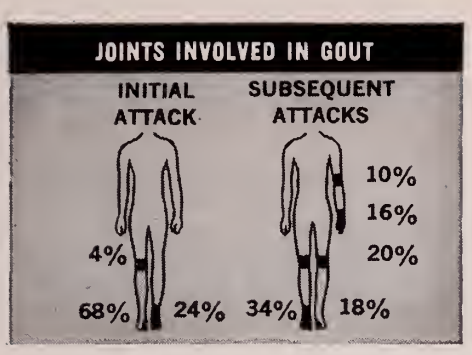
THE essence of recent research on the effects of wine in renal disease indicates (1) that wine in moderate quantities is non-irritative to the kidneys; (2) that wine increases glomerular blood flow and diuresis; (3) that it is useful in minimizing acidosis, and (4) that properly used in selected patients, wine can brighten an otherwise monotonous and unappealing diet.

The Superior Diuretic Action of White Wine— The diuretic properties of wine have been the subject of intensive study. Interestingly, the diuretic action of white wine, and particularly sweet white wine, has been found to be superior to that of red wine.

White wine, therefore, is prescribed with benefit in nephritis, especially that associated with hypertension and arteriosclerosis. Wine is not suggested in cases of renal insufficiency.

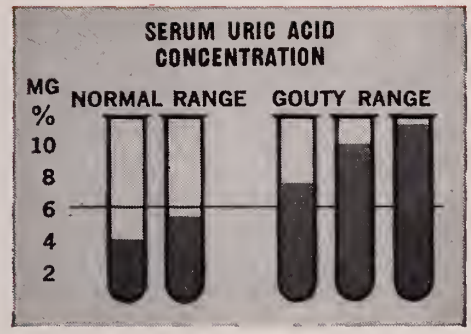
The Buffers in Wine—Such buffering agents as natural tartrates and phosphates in wine prevent the acidosis which normally tends to follow the ingestion of alcohol. Used in renal disease, therefore, wine tends to minimize acidosis and maintain the alkaline reserve.

An extensive bibliography is now available showing the important role of wine in various phases of medical practice. A digest of current findings with specific references to published medical literature is yours for the asking. Just write for your copy of *"Uses of Wine in Medical Practice"* to Wine Advisory Board, 717 Market Street, San Francisco 3, California.



1. Recurrent joint pain followed by long periods of complete remission. *(Percentages refer to incidence.)*

2. Enlargement of bursae such as in this case involving the olecranon bursa.



3. Elevated serum uric acid levels.

4. Colchicine test: full dose (0.5 mg.) every 1 to 2 hours until pain is relieved or nausea, vomiting or diarrhea occur. The test requires usually 8 to 16 doses. Pain relief is highly indicative of gout.

FROM THESE FINDINGS...SUSPECT GOUT:

℞ BENEMID®

PROBENECID

A SPECIFIC FOR GOUT

Once findings point to gout, long-term management can be started with BENEMID. This effective uricosuric agent has these unique benefits:

- Urinary excretion of uric acid is approximately doubled.
- Serum uric acid levels are reduced.
- Uric acid deposits (tophi) in tissues are mobilized.
- Formation of new tophi can often be prevented.
- Fewer attacks and severity is reduced.

RECOMMENDED DOSAGE: 0.25 Gm. (½ tablet) twice daily for one week followed by 1 Gm. (2 tablets) daily in divided doses.

BENEMID is a trade-mark of Merck & Co., Inc.

MSD

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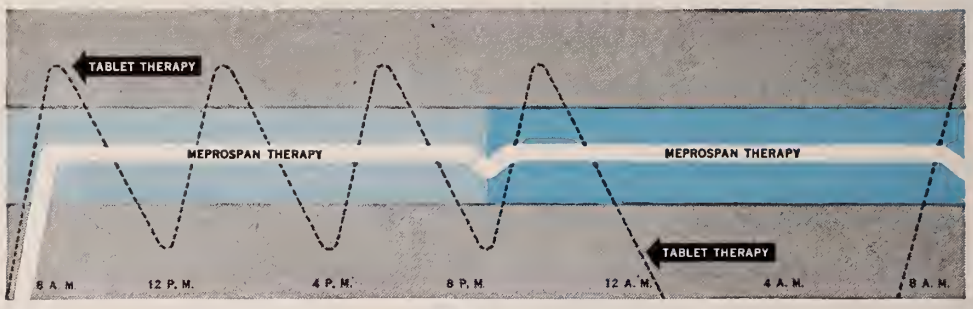
New... meprobamate prolonged release capsules

Evenly sustain relaxation of mind and muscle 'round the clock



TWO MEPROSPAN CAPSULES IN THE MORNING RELIEVE ANXIETY, TENSION AND SKELETAL MUSCLE SPASM THROUGHOUT THE DAY.

TWO MEPROSPAN CAPSULES AT BEDTIME PROVIDE UNINTERRUPTED SLEEP THROUGHOUT THE NIGHT.

Meprospan*

MEPROBAMATE IN PROLONGED RELEASE CAPSULES

- maintains constant level of relaxation
- minimizes the possibility of side effects
- simplifies patient's dosage schedule

Dosage: Two Meprospan capsules q. 12 h.
Supplied: Bottles of 30 capsules.
Each capsule contains:
Meprobamate (Wallace) .....200 mg.
2-methyl-2-n-propyl-1,3-propanediol dicarbamate

Literature and samples on request.

WALLACE LABORATORIES, *New Brunswick, N. J.*

* TRADE-MARK CME-6598-48

for simultaneously combating inflammation, allergy, infection

METIMYD ophthalmic suspension
(0.5% prednisolone acetate and 10% sulfacetamide sodium—5 cc. dropper bottle)

METIMYD ointment with neomycin
(0.5% prednisolone acetate, 10% sulfacetamide sodium and 0.25% neomycin sulfate—⅛ oz. tube)

in external eye disorders look to these topical healing aids

for ocular allergies

METRETON ophthalmic suspension
(0.2% prednisolone acetate and 0.3% CHLOR-TRIMETON®—5 cc. dropper bottle)

standard for ocular infections

Sodium SULAMYD ophthalmic solution 30%
(Sulfacetamide Sodium U.S.P.—5 and 15 cc. dropper bottles)

Sodium SULAMYD ophthalmic solution 10% with Methylcellulose 0.5 (15 cc. dropper bottle)

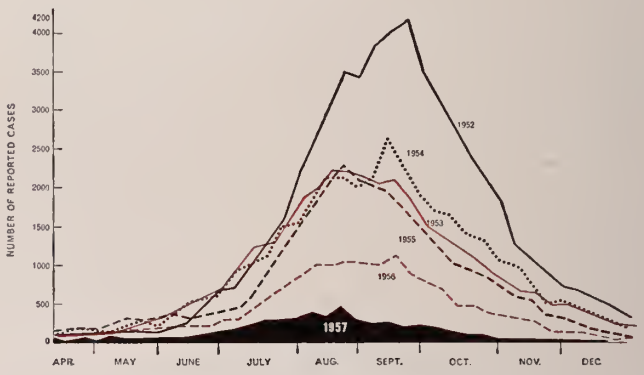
Sodium SULAMYD ophthalmic ointment 10%
(⅛ oz. tube)

SCHERING CORPORATION • BLOOMFIELD, NEW JERSEY *Schering*

M-J-128

A MIRACLE IN OUR TIME ?

At the last accounting,[1] physicians throughout the country had administered at least one dose of poliomyelitis vaccine to 64 million Americans—all three doses to an estimated 34 million. Undoubtedly, these inoculations have played a major part in the dramatic reduction of paralytic poliomyelitis in this country.



Incidence of polio in the United States, 1952-1957
(data compiled from U.S.P.H.S. reports)

vaccine is plentiful for the job remaining

There are still more than 45 million Americans under forty who have received no vaccine at all and many more who have taken only one or two doses.

As it was phrased in a public statement by the Department of Health, Education, and Welfare:

> "*It will be a tragedy if, simply because of public apathy, vaccine which might prevent paralysis or even death lies on the shelf unused.*"[2]

Eli Lilly and Company is prepared to assist you and your local medical society to reach those individuals who still lack full protection. *For information see your Lilly representative.*

1. *J. A. M. A.*, 165:21 (*November 23*), *1957.*
2. *Department of Health, Education, and Welfare: News Release, October 10, 1957.*

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U. S. A.
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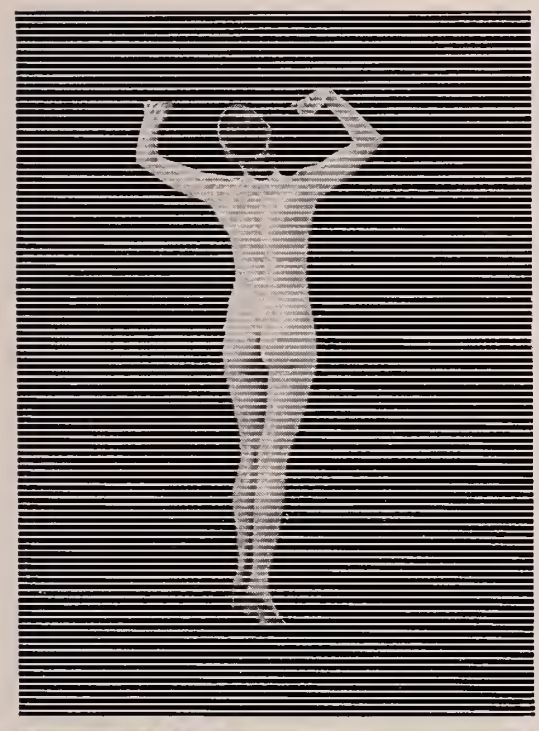
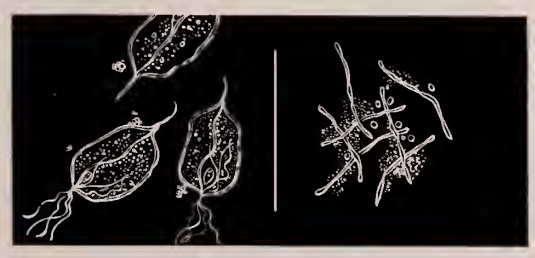
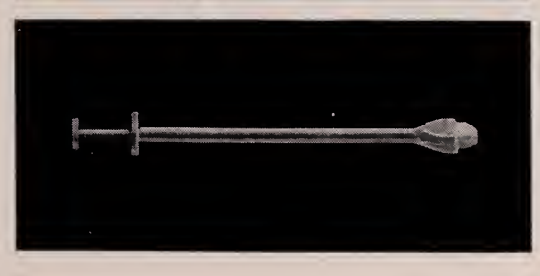
CHEMOTHERAPY PLUS FLORA CONTROL

Floraquin®

Destroys Vaginal Parasites
Protects Vaginal Mucosa







Vaginal discharge is one of the most common and most troublesome complaints met in practice. Trichomoniasis and monilial vaginitis, by far the most common causes of leukorrhea, are often the most difficult to control. Unless the normal acid secretions are restored and the protective Döderlein bacilli return, the infection usually persists.

Through the direct chemotherapeutic action of its Diodoquin® (diiodohydroxyquin, U.S.P.) content, Floraquin effectively eliminates both trichomonal and monilial infections. Floraquin also contains boric acid and dextrose to restore the physiologic acid pH and provide nutriment which favors regrowth of the normal flora.

Method of Use

The following therapeutic procedure is suggested: One or two tablets are inserted by the patient each night and each morning; treatment is continued for four to eight weeks.

Intravaginal Applicator for Improved Treatment of Vaginitis

This smooth, unbreakable, plastic device is designed for simplified vaginal insertion of Floraquin tablets by the patient. It places tablets in the fornices and thus assures coating of the entire vaginal mucosa as the tablets disintegrate.

A Floraquin applicator is supplied with each box of 50 tablets. G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

SEARLE

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Volume 57 APRIL 1958 Number 4

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Air Safety

The *Medical Forum* in this issue reports a Washington furor over lax medical administration in the Civil Aeronautics Administration. It appears that the nation's commercial airline pilots have been flying for years without adequate medical examination or periodic physical checkups. In some cases, chiropractic examination has substituted for medical advice!

Wisconsin should take pride that the current Capitol hubbub was set off by an AMA resolution presented last December by Dr. L. O. Simenstad of Osceola. A licensed pilot himself and an avid promoter of his small town's small airport, it's not so surprising that he, rather than a resident of one of the nation's leading air centers, should see the need for health reform in the civil aviation system. Wisconsin physicians have a history of the "forward look" in public health and health legislation.

One Step Ahead of Blue Shield?

Someone has said that our profession must always be one step ahead of Blue Shield. This is roughly equivalent to saying that the horse should be in front of the cart. The main point is that physicians—for our own sake as well as for the good of our patients—must always lead and guide this prodigious child of ours, Blue Shield—not vice versa.

Fifteen years is not a long period in the brief span of the average man's adult life. Yet, 15 years ago Blue Shield was little more than a gleam in the eyes of a few groups of doctors in various parts of the U. S. A. Today Blue Shield is a nationwide association of medically-approved, non-profit, prepayment plans that are paying aggregate benefits at a rate of more than half a billion dollars per year for covered services rendered by physicians.

These 70-odd locally-sponsored and locally controlled plans are engaged in an endless effort to help our profession provide an ever greater degree of medical care security to more than 40 million Blue Shield subscriber-members.

If Blue Shield has a big job to do, physicians have a bigger one, for Blue Shield is "our baby"—to nurture and direct. We cannot escape the ultimate responsibility for what Blue Shield is, and for what it snall become. Nor would any of us want to deny our profession the credit for having built this mechanism that serves as a bridge of mutual benefit between doctors and patients.

Our patients need Blue Shield until and unless private insurance is willing to and can supply this economic need. Blue Shield needs the guidance that only the medical profession can give it if Blue Shield is to do the job for which it was created.

respiratory infections
gastrointestinal infections
genitourinary infections
miscellaneous infections

immediate therapeutic response

use

Sumycin

Squibb Crystalline Tetracycline Phosphate Complex

intramuscular

with Xylocaine*

250 mg. per 1 dose vial
100 mg. per 1 dose vial

- when oral therapy is contraindicated (vomiting, dysphagia, intestinal obstruction, gastrointestinal disorders)
- when the patient is comatose or in shock
- postoperatively

1. fast peak blood and tissue concentrations
2. high cerebrospinal levels
3. for practical purposes, Sumycin is sodium-free

Each vial contains tetracycline phosphate complex equivalent to 250 mg., or 100 mg., of tetracycline HCl. (Note: 250 mg. dose may produce more local discomfort than the 100 mg. dose.)

FLEXIBLE DOSAGE FORMS FOR CONTINUING ORAL THERAPY

	Tetracycline phosphate complex equiv. tetracycline HCl (mg.)	Packaging
Capsules (per capsule)	250	Bottles of 16 and 100
Half Strength Capsules (per capsule)	125	Bottles of 16 and 100
Suspension (per 5 cc. teaspoonful)	125	60 cc. bottles
Pediatric Drops (per cc.—20 drops)	100	10 cc. bottles with dropper

SQUIBB

Squibb Quality—the Priceless Ingredient

SUMYCIN® IS A SQUIBB TRADEMARK *T.M.® ASTRA PHARMACEUTICAL PRODUCTS, INC.

Society Proceedings*

Dodge

A film entitled "Conquest of Space" by Wernher Von Braun was presented at the February 27 meeting of the Dodge County Medical Society held at St. Joseph's Hospital in Beaver Dam.

During the business meeting, the members discussed the county fee schedule and endorsed the cytology program of the State Medical Society and the Wisconsin Division, American Cancer Society. The subject of social security for physicians was discussed and the Society expressed opposition.

Eau Claire—Dunn—Pepin

The Eau Claire-Dunn-Pepin County Medical Society met February 24 in the Holiday Room of the Eau Claire Hotel. Thirty-four members were present.

Guest speaker for the meeting was *Dr. David W. Smith*, of the Department of Pediatrics at the University of Wisconsin Medical School, who lectured on abnormalities of sex differentiation in the newborn and in infants.

It was decided during the business session that the school round-up program is to be intensified with a tape recording as an aid to the individual speaker.

Fond du Lac

The Elks Club in Fond du Lac was the meeting place of the Fond du Lac County Medical Society on January 23. "Practical Approach to Allergy" was the subject chosen by the principal speaker, *Dr. James C. Curry* of Appleton.

Several matters were considered at the business session. Action was taken to purchase a combination slide projector and the group approved "Health Magazine of the Air". The members' discussion on the high patient cost at the new county home was referred to the Geriatrics Committee. The possibility of uniform insurance reporting forms (other than Blue Shield) was also discussed.

Grant

At the Grant County Medical Society meeting held February 13 at the Lancaster Memorial Hospital two guest lecturers, Dr. R. H. Lee, psychiatrist from Dubuque, Iowa, and Mr. D. L. Kyer of Cedar Rapids, administrator and director of a mental health institution in Iowa, spoke on mentally dis-

* Physicians whose names are printed in italics are members of the Society.

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Hubert H. Blanchard, M. D.
John E. Leach, M. D.
Lloyd F. Jenk, M. D.
Richard O. Barnes, M. D.
John R. Whitty, M. D.

Preston W. Thomas, M. D.

turbed children and the advisability of a guidance center. County Judge George F. Franz completed the program with a talk on cases of juvenile delinquency in the county court.

After the discussions a business meeting was held during which the members decided to continue the orthopedic clinic and the TB mobile unit. The following 1958 officers were also named:

H. L. Doeringsfeld—President
Herman Rosmann—Vice-President
H. W. Carey—Secretary-Treasurer
E. C. Howell—Delegate
M. W. Randall—Alternate Delegate

Green

Senator Robert Travis addressed the members of the Green County Medical Society and their wives at a meeting held February 4 at the Monroe Country Club. Invited guests for the dinner meeting were members of the Green County Dental Society and their wives. Senator Travis spoke to the group on important bills presented in the legislature during the last session.

The main topic of business for the evening was the election of officers. Those chosen were: *Drs. Leslie G. Kindschi*, President; *John M. Irvin*, Vice-President; *John A. Frantz*, Secretary-Treasurer; *Robert G. Zach*, Delegate; and *William E. Hein*, Alternate Delegate.

Dr. Leslie G. Kindschi (right), Monroe physician, was congratulated by State Sen. Robert Travis, Platteville, after being elected president of the Green County Medical Society in February. Doctor Kindschi succeeded Dr. Melvin Stuessy of Brodhead. *(Monroe Times photo)*

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metaphosphate produced markedly higher blood levels than capsules containing either the corresponding base or the hydrochloride alone. In addition, the average levels derived from the tetracycline base or the chlortetracycline base were higher than those produced by the corresponding hydrochloride though lower than those resulting from the mixture containing the base and sodium metaphosphate. In the study with chlortetracycline[6] capsules containing a mixture of the hydrochloride and sodium metaphosphate were also included in the crossover, and the average levels produced by these capsules were the same as with the mixture of chlortetracycline base with sodium metaphosphate.

Although the enhancement of blood levels of tetracycline by phosphate, either complexed to the tetracycline or mixed with the base or the hydrochloride, thus seemed fairly well established, some doubts still remained because certain reliable observers (including many whose results have not been published) failed to confirm the findings with the materials and methods they used. Further confusion seemed to be added by a subsequent report of Welch et al.,[7] who, in repeating a crossover study with capsules of tetracycline phosphate complex and tetracycline hydrochloride with and without sodium [illegible] phate, foun[illegible]

"...Tetracycline hydrochloride and citric acid, in an encapsulated mixture, produced higher serum concentrations and greater urinary excretions, and hence better absorption of tetracyclines, than any other preparation studied..."

[illegible] of sod[illegible] metaphosphate were published simultaneously with the last mentioned report of Welch et al.[7] These data were based on thoroughly controlled studies both in rats[8] and in man[9] and include additional findings that serve to explain, fairly conclusively, the various discrepancies that have been mentioned.

The experiments in rats[8] were carried out to study the effects of citric acid, dicalcium phosphate, sodium metaphosphate, food, oil and sorbitol on the serum antibacterial activity produced by the administration of tetracycline hydrochloride or tetracycline base. Citric acid administered in equal weight with tetracycline hydrochloride gave the highest concentrations of all the preparations studied. No enhancing effect was obtained from citric acid when given with tetracycline base. Dicalcium phosphate and food resulte in lower, and sodium metaphosphate in higher, seru antibacterial activity than was observed in their ab sence. Oil and sorbitol did not interfere with tetra cycline absorption.

Dicalcium phosphate is widely used as a filler i various capsules, including those of the tetracycline The authors cite a large number of other studies tha implicate the presence of calcium ions as the cause o the reduced absorption of tetracyclines and show tha citric acid can partially neutralize this effect. Th depressing effect of food on the serum levels of tetra cycline is likewise explained by the goodly amount o minerals contained in commercial laboratory diets and they postulate that the multivalent cations ma be responsible for the poorer absorption of the drug The authors could not explain the failure of citri acid to enhance serum concentrations when administered with tetracycline base in contrast to its marke effect when given as the hydrochloride. However they hypothesized that the ability of citric acid t enhance serum levels of tetra[illegible] its ability to form complex[illegible] unavailable for [illegible]

[illegible] meta- [illegible] phosp[illegible] plex.

[illegible] addendum to the last mentioned paper of [illegible] et al.[7] indicates that in their study the capsules of tetracycline hydrochloride, chlortetracycline hydrochloride and tetracycline phosphate complex all contained dicalcium phosphate as a filler, whereas the capsules containing citric acid and sodium hexametaphosphate did not contain any dicalcium phosphate. This could clearly explain the discrepancies noted in that study. Likewise, the inconsistencies in other studies may very well have been due to the presence of calcium as fillers in some of the capsules and not in others.

This, however, fails to explain the most recent findings of Welch and Wright,[10] who compared the absorption of three capsules, each containing 250 mg. of oxytetracycline hydrochloride — one without any adjuvant, one with 250 mg. of citric acid and the third with 380 mg. of sodium hexametaphosphate; no other filler was contained in any of these capsules. In triple

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Editorial.
The New England Journal of Medicine.
258:97-99, (January 9) 1958

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Polk

Twenty members of the Polk County Medical Society met February 20 at the Dalles House in St. Croix Falls for a dinner meeting. They heard Dr. Dewain J. Paal, obstetrician and gynecologist of Minneapolis, Minnesota, lecture on the topic "Toxemias of Pregnancy." Doctor Paal and a resident from St. Mary's Hospital, Minneapolis, led a round-table discussion on obstetrics and gynecological office procedures. *Dr. Rex Graber*, District Health Officer of Chippewa Falls, discussed immunization procedures.

Racine

On February 20 the Racine County Medical Society held its regular meeting. The members met at the Racine Country Club.

Sauk

The Sauk County Medical Society held a dinner meeting at the Warren Hotel in Baraboo on February 11. Guest speakers on the program were *Drs. Nathan J. Smith*, chairman of the Department of Pediatrics at the University of Wisconsin, and *David W. Smith*, instructor in the same department, who talked on the pediatric program, covering treatment of iron deficient anemias of children and sex determination in the newborn.

Walworth

"Recent Concepts in Dermatologic Therapy" was the subject of a speech presented by *Dr. H. M. Levin*, a Delavan dermatologist, to the members of the Walworth County Medical Society. Their meeting was held February 21 at the Crossroads in Elkhorn.

Washington–Ozaukee

Eighty members attended the February 27 meeting of the Washington-Ozaukee County Medical Society at the Grafton Hotel. Miss Mary Muldoon, a representative of the Bell Telephone Company, spoke on telephone courtesy. A report was also made by Miss Geraldine Junghans on the progress made by the Medical Assistants Society since its organization in the area two years ago.

Winnebago

A joint meeting of the Winnebago County Medical Society and the Winnebago County Bar Association was held on January 30 at the Athern Hotel in Oshkosh. A film, "The Doctor Defendant," was shown to augment the talk presented by Mr. John Moore, bar association president, pointing out some areas of practice wherein the cooperation of the two professions is essential in producing satisfactory results for the public. *Dr. Guy W. Carlson* of Appleton commented on activities of the medical profession in seeking to promote public health measures.

Wood

The Wood County Medical Society met January 23 to elect officers for 1958. The members who met at the Casa Loma in Marshfield chose *Dr. Wallace L. Nelson*, president, *Dr. Stanley G. Custer*, vice-president, and *Dr. James R. Heersma*, secretary. Also named were *Drs. Paul F. Doege, Richard Rowe* and *Charles Arendt* to the board of censors.

The scientific portion of the program was presented by *Dr. John Thompson*, Nekoosa, who talked on "Gas Gangrene."

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THE MEDICAL FORUM

COUNCIL OK'S PHYSICIAN-ANCILLARY PERSONNEL POLICY

COUNCIL REVIEWS W.P.S. PROGRAM

MADISON—A review and report of Wisconsin Physicians Service came before the State Medical Society's Council at its winter meeting.

It was reported that:

The transfer of records and functions involving sales and enrollment services during the period Oct. 1-Feb. 1 was carried on in orderly fashion. W. P. S. previously had contracted with Blue Cross for the purchase of these services.

The sales of "A" contracts and the "no-fee schedule" program are increasing markedly.

Blue Shield, in all its literature, promotion and sales effort, recommends Blue Cross as its companion program for hospital coverage.

CONFERENCE ON ATHLETIC INJURIES SET FOR NOV. 7

MADISON—Initial plans for a statewide Conference on Athletic injuries, to be held in Milwaukee Nov. 7, were outlined by a planning committee in April.

Coaches, school administrators and physicians will be invited to attend. The conference is scheduled during the annual state teachers' convention.

Subjects to be included on the program are knee and ankle injuries, head and facial injuries, emotional factors in athletics, hernia, heart, growth, fatigue, conditioning, taping and physiotherapy.

The conference was proposed by the State Medical Society's Division on School Health. It had been noted that similar conferences held out-of-state and at Racine (on a local basis) proved unusually successful and had met an urgent need.

The program will be presented under the sponsorship of the State Medical Society's Charitable, Educational and Scientific Foundation.

Ethical Principles Outlined In New S.M.S. Statement

MADISON—A formal statement of policy on ethical practices relating to physician associations with ancillary personnel has been issued by the Council of the State Medical Society.

Copies of the statement have been directed to the attention of county medical society secretaries who were requested to note the action of the Council and forward it to appropriate committees.

The statement:

STATEMENT ON ETHICAL PRINCIPLES

"A problem which is frequently presented to the Secretary's office, or to a committee, involves the practice in some areas of indicating ancillary personnel associated in a physician's practice. In some instances such ancillary personnel, engaging in a limited practice and on a 'free lance' basis, establish their own office but share certain facilities, such as a waiting room, with a physician and surgeon. 'Ancillary personnel' includes those engaged in the fields of podiatry (chiropody), physical therapy, in some cases optometry, clinical psychology, and others. As used in this statement, 'ancillary personnel' does not refer to the practice of dentistry.

"The Council has not recorded formal action upon these inquiries in the past, but has known of informal advice that the *employment* of such individuals by physicians, and for the purpose of utilizing their training under physician direction for patient care, is not unethical.

"But physicians have been advised that designation of these individuals on letterheads, on professional announcements, or in the physician's office itself, is improper.

"Such practice has been felt objectionable on the basis that it may well create in the minds of the patient that these individuals are of training comparable to that of the medical profession and have achieved a professional equiva-

(Continued on page 46)

W.P.S. Extends Radiation Coverage

MADISON—Future coverage provided by Wisconsin Physicians Service will include benefits for radiation therapy of proven malignancies except of the skin. This extension of benefits was approved by the Commission on Medical Care Plans recently.

All 143,000 contracts of W. P. S. already provide benefits for diagnostic x-rays associated with surgery or maternity, and 18,000 of these also include radiation therapy.

W. P. S. reported slight growth in 1957, with a sharp increase in sale of "A" and "no-fee schedule" contracts in 1958. Currently, it has 128 groups (about 31,000 persons) covered by the no-fee programs, covering 37 different counties.

In other action, the commission:

Authorized inclusion of certain dental benefits as a regular part of W. P. S. contracts in the future. This will cover certain types of oral surgery performed by dentists, upon recommendation of a physician, and when hospitalization is required.

ASK LIAISON GROUP

Asked the Wisconsin State Dental Society to create a liaison committee to help administer the new benefits, which will be associated with an illness or injury for which W. P. S. would otherwise provide benefits.

Invited Blue Cross and Surgical Care of Milwaukee County to join W. P. S. in a joint exhibit during the Annual Meeting of the society in Milwaukee in May.

Urged county medical societies to invite members of the commission and the society staff to present material on enlargement of Blue Shield programs and the "no-fee schedule" contracts.

LA CROSSE CHAMBER HONORS DR. GUNNAR GUNDERSEN

Tribute Paid For Outstanding Service To Community

LA CROSSE—Because of dedicated physicians like Dr. Gunnar Gundersen and active chambers of commerce like the one in La Crosse, "our citizens can feel secure in the high quality of the medical service in their communities."

This statement was made by Dr. David B. Allman, Atlantic City, N. J., 111th A.M.A. president, here to aid in a night of tribute to Dr. Gundersen, president-elect of the A.M.A.

The La Crosse physician, a member of a famous medical family, received the 12th annual President's Award plaque, presented to outstanding citizens annually by the La Crosse County Chamber of Commerce.

Dr. Allman, after praising the chamber and his successor for their community-minded record, said:

"American physicians are in the forefront as proponents of the free enterprise system. Local chambers of commerce like yours are potentially the strongest single force in existence to perpetuate our free enterprise system.

"Together, they can use their combined strength to realize further improvement in the general welfare, the living standards and the economic conditions of all communities."

He also leveled an attack on social planners leaning toward cradle-to-grave welfare philosophy, saying:

"Now socialistically-minded planners and politicians are advocating a federally-financed and controlled system of medical care. They are working upon the false premise that it is our government's function to provide for the personal needs of all her citizens, and that the way to cure an ill—be it physical or economic—is to appropriate enough money to some government bureau.

"The consequences of this trend include having medicine and medical care become completely subservient to government. By-products of this would be increasing government cost; decreasing liberties of the patient and his doctor; impairing quality of medical care, and destroying our way of life as it stifles those two forces which have helped to develop our country —personal initiative and personal responsibility."

If things are left alone, Dr. Allman continued, "I predict death rates will be reduced to an absolute minimum; the level of health will be raised to a maximum, and the economic problems of illness will be solved in a manner fitting the American temperament and tradition."

He praised medical progress of the past 30 years, saying it showed what could be done without government interference and control.

Guests from all sections of Wisconsin attended the testimonial dinner, including Dr. H. E. Kasten, Beloit, president of the State Medical Society, and three past presidents of the society, Drs. W. D. Stovall, Madison; L. O. Simenstad, Osceola, and J. C. Griffith of Milwaukee.

LA CROSSE—Dr. Gunnar Gundersen, La Crosse, scheduled to become the AMA'S 112th president in June, was honored by citizens of his home community recently. He received the 12th President's Award plaque, presented by the La Crosse County Chamber of Commerce. From left in picture above: Arnold C. Trimble, chamber president; Dr. David B. Allman, Atlantic City, N. J., AMA president, and dinner speaker; Dr. Gundersen, and Bernard L. Decheine, president-elect of the chamber. Dr. Gundersen was cited for "loyal, untiring service for the betterment of many, and outstanding personal civic service to the community."

—(La Crosse Tribune)

NOTE!

Reminder: The dates of the S.M.S. Annual Meeting in Milwaukee are May 6, 7 and 8.

PUPILS HEAR ABOUT MEDICAL CAREER FIELD

GREEN BAY—Pupils from nine high schools attended a "Medic Career Night" at Green Bay West high school this spring.

A student club, the West Future Medics, sponsored the session, and arranged talks by representatives of 15 different medical fields.

Dr. Jack A. Killins, Green Bay, spoke on the subject "Intangible Satisfactions of a Medical Career," also citing the services performed by physicians and other members of the health team to fellow citizens.

The pupils also heard talks on medical records library work, medical art, dietetics, dental hygiene, medical social work, medical secretarial work, nursing, occupational therapy, physical therapy, pharmacy, x-ray technology and hospital administration. Consultation periods followed the talks.

The program was worked out in cooperation with the Brown County Medical Society and allied organizations.

Start Poison Information Center At University Hospitals, Madison

MADISON — A 24 hour-a-day, seven day-a-week service for Wisconsin physicians is now available at the Poison Information Center established this spring at University Hospitals, Madison.

Dr. Nathan J. Smith, professor and head of the University of Wisconsin Medical School Department of Pediatrics, has direct charge of the center and staff headed by Dr. Theodore T. Bruns, research associate in pediatrics. Dr. Bruns served as director of the Poison Control Center of Los Angeles County before coming to Wisconsin.

Dr. Frederic E. Mohs, of the center staff, said there are 250,000 potentially poisonous products now known, and that it is impossible for any physician to be familiar with all of them.

"There has been an encouraging decrease in the number of deaths from accidental poisoning in the last several years as a result of educational campaigns aimed at the prevention and proper treatment of poisoning," Dr. Mohs said. "The importance of keeping poisons out of reach of children, and of keeping the materials in their original containers has been widely publicized, as has the danger of incorporating aspirin and other medications in candy and sweet tasting syrups.

"The importance of prompt and correct treatment of poisoning is becoming generally known, as is the paramount essentiality of calling a physician at once when poison or suspected poison has been swallowed."

GREAT NEED

To further decrease the toll—1,500 cases of fatal poisoning a year—the educational program should be improved as much as possible, Dr. Mohs said. There were 200,000 cases of non-fatal poisoning in this country last year.

Dr. Mohs said the information provided by the University Hospitals Center should expedite prompt, accurate treatment in cases of accidental poisoning, and do much to reduce fatalities and morbidity in Wisconsin.

This problem has been a concern of several State Medical Society committees for some time, particularly of the Division of School Health. The society has worked to encourage the formation of such centers as this one, and another established earlier in Milwaukee.

The National Clearinghouse for Poison Control Centers, a service of the U.S. Department of Health, Education and Welfare, supplied the Madison center with a card file of many potentially poisonous drugs and commercial products. This will be built up at the rate of 30 to 50 additions a month, it was estimated.

The cards list symptoms and medical treatment for each item. Various reference books and brochures on the toxicology of commercial products also will be kept on file. Consultation with specialists in various fields at the University of Wisconsin also is available when questions arise.

S.M.S. RENEWS MEDICARE CONTRACT

MADISON—The State Medical Society has renegotiated its contract with the federal government for operation of the MEDICARE program for dependents of military personnel.

It continues on the "no-fee schedule" pattern. In doing so, the society rejected efforts of the government to define "quality" of medical services and to express "ethical considerations" as part of its contract.

The society also opposed inclusion of certain medical services in the hospital administration portion of the contract.

COUNCIL REVIEWS S.M.S. BUDGET

MADISON—The State Medical Society anticipates revenues of $339,570 and expenditures of $316,-298 in 1958.

Reviewed by the Council, the budget revenues include $220,770 in dues and $118,800 from advertising in The Wisconsin Medical Journal, Annual Meeting, clinics and other sources.

This allows a leeway of $23,272 between income and outgo.

$1,000 DONATED TO FOUNDATION

MADISON—The Frank G. Brotz Family Foundation Inc., of Sheboygan, has donated $1,000 to the Charitable, Educational and Scientific Foundation of the State Medical Society.

The money is to be used exclusively for nurses' scholarships in Sheboygan County, as selected by the Sheboygan County Women's Auxiliary to the State Medical Society.

Mr. Brotz was, until his death several years ago, an industrial engineer who served as plant manager of the Kohler Company for many years.

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MILWAUKEE WISCONSIN

PRESIDENT PROPOSES MORE STATE RESPONSIBILITIES

Urges Long-Range Planning To Reduce Federal Expenditures

WASHINGTON—Action should be taken to return to the states more responsibility for providing public assistance, President Eisenhower told Congress in his budget message.

Asking the lawmakers to reduce a significant number of health-welfare appropriations, the chief executive stated he hopes to set a new course in federal-state relations. He cited proposed expenditures for labor and welfare activities, totaling $3,600,000,000, some $200,000,000 more than last year.

President Eisenhower told specifically how he would withdraw the U. S. from some welfare programs and at the same time open up new revenue sources so states could take over these operations. He said:

"A large portion of the expenditures for labor and welfare programs consists of grants-in-aid to states and local governments, and cannot be reduced without changes in basic authorizing legislation. At this time, I am proposing revisions in the legislation governing five of these grant programs which will lead to some small reductions in the federal budget for the fiscal year 1959, and to some larger reductions in later years.

"Under these proposals, the proportion or amount of federal participation would be reduced for schools in federally affected areas, for hospital construction, and for public assistance.

"Our technological progress requires a higher level of support for basic scientific research from both private and public sources. I am recommending an expanded program for the National Science Foundation and a new program for the Department of Health, Education and Welfare, both to be closely coordinated."

The president said the initial report of the joint Federal-State Action Committee recommends complete transfer of two programs to the states together with the simultaneous relinquishment of a portion of the local telephone service tax which the federal government now collects. These programs are vocational education and the construction of waste-treatment facilities.

"As I have repeatedly emphasized," he said, "the continued vitality of our federal form of government requires that, to the maximum extent possible, primary responsibility for public programs be shouldered by that level of government most familiar with local problems and most responsive to them.

"We must exercise the utmost restraint in assigning new programs and responsibilities to the federal government, and we should continuously search out those programs and activities now carried on at the national level that can and should be handled by the states or localities."

It is considered unusual for an administration to withdraw publicly from support of a proposal that has wide political appeal.

The Hill-Burton hospital construction program has been in operation for about 10 years. In recent years it has been renewed almost automatically when its scheduled expiration date approached. The president thinks now it is time to alter its objectives and reduce its scope: He declared:

"Expenditures for health programs have increased sharply since 1955. In 1959 the increase will be largely for construction programs already underway. New obligational authority for health activities is being reduced, principally with respect to construction of hospitals. This will not materially affect the planned level of obligations and expenditures for hospital grants in the fiscal year 1959, because prior-year appropriations are available and will be used.

"New obligational authority of $75,000,000 is recommended for 1959. Authorizing legislation for hospital construction grants will expire on June 30, 1959. In view of the progress already made toward meeting community requirements for general beds, the federal program should be modified to meet only the most urgent needs, with emphasis on specialized needs."

President Eisenhower would have Congress go slow in making any further changes at the present time in social security, and he believes action should be taken to return to the states more responsibility for providing public assistance. His message stated:

"Although federal old-age, survivors, and disability insurance provides an increasing share of economic security for the aged, the dependent, and the disabled, the federal government's expenditures for public assistance continue to mount because of the successive amendments increasing the federal matching share.

"These programs are now well established. . . Proposals will be sent to Congress for modernizing the formulas, and for gradually reducing federal participation.

"Also, fundamental changes have taken place in our society. These require us to reconsider the laws providing veterans benefits which now overlap other growing public benefit and welfare programs. There will be recommendations for specific adjustments."

EULOGY OF THE DOCTOR

There are men and classes of men that stand above the common herd: the soldier, the sailor, the shepherd not infrequently; the artist rarely; rarelier still the clergyman, the physician almost as a rule. He is the flower of our civilization and when that stage of man is done with, only to be marveled at in history, he will be thought to have shared but little in the defects of the period and to have most notably exhibited the virtues of the race.

Generosity he has, such as is possible only to those who practice an art and never to those who drive a trade; discretion, tested by a hundred secrets; tact, tried in a thousand embarrassments; and what are more important, herculean cheerfulness and courage.

So it is that, he brings air and cheer into the sick room and often enough, though not so often as he desires, brings healing.—Robert Louis Stevenson.

Stress Urgent Need For New Laws Tightening Air Pilot Exam Rules

Dr. Simenstad has Lead Role in Change

WASHINGTON—The Civil Aeronautics Board, rejecting the medical opinion of the Civil Aeronautics Administration, recently held that flying licenses should not be denied to three applicants because of their history of mental illness.

This action pointed up the seriousness of a resolution adopted by the A. M. A. House of Delegates last December which recommended establishment of an adequate and competent medical department in the Civil Aeronautics Commission.

The resolution was introduced by Dr. L. O. Simenstad, a Wisconsin alternate delegate and past president of the State Medical Society of Wisconsin. Dr. Simenstad is well known as a private pilot and as a member of the Wisconsin Aeronautics Commission.

He pointed out that the C. A. A. is responsible for air safety in this country, and that the administration's medical department is grossly inadequate to perform periodic examination of flyers, examination of accidents, and selection, training and supervision of examiners. In some instances, Dr. Simenstad said, chiropractors are performing the employment examination for pilots.

The House urged the A. M. A. to support appropriate legislation to accomplish the purpose of Dr. Simenstad's resolution.

The Aero Medical Association, holding its annual meeting in Washington this spring, also discussed with Congressional personnel and C. A. A. officials similar steps to tighten the regulations.

The Washington Report on the Medical Sciences has reported that since the board decision on licensing, one of the three pilots had died. He had been a World War I airman with a history of manic-depressive diagnosis.

Being explored is the feasibility of a campaign for enactment of Senate Bill 1045 to give medicine the authority and autonomy now lacking in federal regulatory programs. The lay veto power over medical findings, under the measure, would be ended. The bill currently is in the hands of the Senate Commerce Committee.

CHANGE NAME OF CHIROPODISTS ASSOCIATION

CHICAGO—The National Association of Chiropodists has announced it has changed the name of its organization to the American Podiatry Association.

Its publication will now be known as The Journal of the American Podiatry Association.

The dual terminology was said to have saddled the profession with confusion in educational, military and governmental circles.

Officers of the Wisconsin State Board of Chiropody Examiners said the change would take place slowly at the state level.

It was explained that the word "chiropodist," often confused with "chiropractor," is considered semantically incorrect.

"Chiropodist" was derived from the Greek word "cheir," meaning hand, and "pous," or "pod," meaning foot.

"Podiatrist" is believed semantically correct, and was derived from the Greek word "poud (pod)" which means foot, plus "iatros," meaning healing, and more nearly describes the work of a "foot doctor."

Eastern states have seen the word "podiatry" used for many years, but it was never commonly used in the midwest or in western states.

The change was made by the association's House of Delegates at its annual meeting in Chicago.

Commission Asks Meeting With Blue Cross Officers

MADISON—The State Medical Society's Commission on Medical Care Plans adopted a resolution at its March meeting inviting the Board of Directors of Blue Cross and its executive officers to a joint annual conference with commission members.

The commissioners said the termination of the formal principal-agent relationship "should not operate to terminate the friendly interest of each in the other, and their community of effort in serving the people of Wisconsin as companion non-profit programs."

The resolution proposes the first meeting for 1959, and that responsibility for planning the meetings be alternated between Blue Shield and Blue Cross.

STUDY OF AGED ENDORSED BY COUNTY DOCTORS

GREEN BAY — The Brown County Medical Society has voted unanimous support for a proposed rehabilitation study program for aged persons in Brown County.

The county was selected as the site for the first demonstration program in the state on nursing home care of aged and chronically ill persons. To be paid for by federal funds, the program will be directed by the State Board of Health.

Preliminary plans are being studied by Dr. George M. Shinners, Green Bay, district state health officer, and other area physicians.

The society also participated in and supported the Green Bay Science Fair held at WBAY-TV in late March.

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Inquiries Invited

TRIBUTE PAID TO WISCONSIN DOCTORS, S.M.S., IN NEW BOOK

MADISON—Thirteen years of research went into a new book, "The Story of Medicine in Wisconsin," described by its author as a salute to Wisconsin's men of medicine and to the State Medical Society of Wisconsin.

Walt Harris, a former newspaperman in Superior, Ashland and Chicago, is the author. The book, dedicated to "history, education, culture and clean literature," is an outgrowth of the Territorial Wisconsin Centennial celebration at Madison 22 years ago. It represents a huge span of Wisconsin history in capsule-size in both medicine and contemporary fields.

A member of the Wisconsin State Historical Society since 1936, Harris tells the story of medicine in Wisconsin, beginning in 1634 with the arrival of Jean Nicolet, French adventurer, in this area.

The great men of early Wisconsin medicine; the sorcery, witchcraft, ignorance, hucksterism, fakery, superstition; the epidemics; the major discoveries in surgery and drugs; the pioneering spirit of early physicians and their contributions are described in detail.

Matters of national interest including the stomach-function discoveries of Dr. William Beaumont, army surgeon, in the early 1820's at Ft. Crawford in Prairie du Chien, are described in detail.

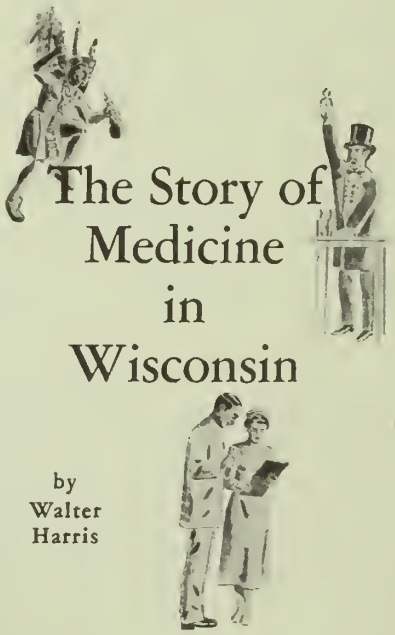
Coming in for particular attention are such men as Dr. Darling, listed as the chief organizer of the State Medical Society; Dr. Nicholas Senn, who served as president of the A. M. A. and made important discoveries; Dr. Cornelius Harper, former state health officer; Dr. John M. Dodd, Ashland, and Dr. Kate Newcomb of Woodruff.

The book outlines the State Medical Society's struggle to eliminate quackery, to establish by way of the legislature a University of Wisconsin Medical School, to sell the precepts of sanitation to the public at large, to acquire through the A. M. A. all the information possible relating to improved surgical techniques and newly-approved drugs.

Many doctors whose lifelong records were of eminence are saluted by name, and there is an honor roll of members of the State Medical Society. There is an account of the progress recently made by the society in acquiring old Ft. Crawford property and making plans for the construction of a shrine to medicine, the Medical Museum of Wisconsin, at Prairie du Chien.

Photographs include those of Dr. R. G. Arveson, Frederic, recent recipient of the society's highest award; Dr. L. O. Simenstad, Osceola, like Dr. Arveson, a past president of the society; Dr. Beaumont, and Dr. H. E. Kasten, Beloit, 1957-1958 society president.

Copies of the book may be obtained from most bookstores, or from the author at 4317 Bliss st., El Paso, Tex., for $3.75. He is his own publisher.



TWO RENAMED TO EXAMINERS BOARD

MADISON—Two members of the State Board of Medical Examiners have been appointed by Gov. Thomson to succeed themselves, for terms ending in July, 1961.

Reappointed to the board were Dr. Clifford A. Olson, Baldwin, and Dr. Millard Tufts of Milwaukee.

A.M.A. OFFERS WIDE ARRAY OF HEALTH DISPLAYS

CHICAGO—A wide assortment of exhibits on health subjects is available from the A. M. A. The State Medical Society of Wisconsin is available to assist county societies in arranging for their display at any time.

The displays, for use by county medical societies and other medical organizations at no cost except shipping charges, include:

LIFE BEGINS—designed to present a basic concept of the anatomy associated with conception and birth.

YOUR HEART—depicting the pumping action of this vital organ.

YOUR BONES AND MUSCLES—relating to the growth of bones, body structure and muscles.

WE SEE—showing the structure and function of the eye, and explaining common eye disorders.

YOUR BODY—showing, in life-size manikins, the location, size and appearance in three-dimensional form the various organs of the body.

Also available are displays on Digestion, You Can Reduce, Nutrition, Food Facts and Fallacies, Modern Medicine Show, Mechanical Quackery, Testing the Drinking Driver, Cancer, Sinus Trouble, Animals in Research, How Disease Bacteria are Spread, Home Accidents, Diseases Transmitted from Animals to Man, Accidental Poisoning in Children, Farm Accidents, Appendicitis, School Health Service, Immunization, Nursing, Where Your Medical Dollar Goes, Health Today, and You and Your Medical Care.

The A. M. A. Bureau of Exhibits' assistant director is George B. Larson, former assistant secretary of the State Medical Society of Wisconsin.

DR. BOWERS NAMED TO COMMITTEE

WASHINGTON—Dr. John Z. Bowers, dean of the University of Wisconsin Medical School, was named to a committe advising Selective Service and the Office of Defense Mobilization on medical matters. Chairman of the committee is Dr. Elmer Hess, Erie, Pa., past president of the A. M. A.

DEFINE CRITERIA FOR FEDERAL DISABILITY BENEFITS

Individual Impairment Must Be Established By Medical Evidence

MADISON—Doctor, how well acquainted are you with the criteria of disability for Social Security benefits?

In Wisconsin, the state agency cooperating with the Social Security Administration in making disability determinations is the State Board of Vocational and Adult Education, Rehabilitation Division.

Physicians have been asked to furnish medical evidence with regard to disability for certain applicants for Social Security benefits since 1955. The criteria are not dependent on any determination by other organizations or other federal agencies.

For example:

An individual who is considered 100 per cent disabled for VA pension purposes need not necessarily be considered under a disability under the provisions of the Social Security laws.

To clarify the picture, the U. S. Department of Health, Education and Welfare Bureau of Old-Age and Survivors Insurance recently released information with regard to criteria, as defined by law.

This information follows:

DEFINITION OF DISABILITY

To be entitled to disability insurance benefits, an individual must demonstrate that he is unable to engage in substantial gainful activity because of a *medically determinable impairment* which may be expected to be of long-continued and indefinite duration or result in death. In determining whether he is unable to engage in such activity, primary consideration is given to the severity of his impairment but consideration is also given to other factors. The disabling impairment must be established by medical evidence, including appropriate medical tests.

Examples of some impairments which would ordinarily be considered as preventing substantial gainful activity are listed below. The existence of one of these will not, in and of itself, always permit a finding that an individual is under a disability as defined by law. Conditions which fall short of the levels of severity indicated must be evaluated in terms of whether they do in fact prevent the person from engaging in any substantial gainful activity.

Examples:

1. Loss of use of two limbs.
2. Certain progressive diseases which have resulted in the physical loss or atrophy of limb, such as diabetes, multiple sclerosis, or Buerger's disease.
3. Disease of heart, lungs or blood vessels which has resulted in major loss of heart or lung reserve as evidenced by x-ray, electrocardiogram, or other objective findings so that, despite medical treatment, it produces breathlessness, pain, or fatigue on slight exertion, such as walking several blocks, using public transportation, or doing small chores.
4. Cancer which is inoperable and progressive.
5. Damage to the brain or brain abnormality which has resulted in severe loss of judgment, intellect, orientation or memory.
6. Mental disease (e.g., psychosis or severe psychoneurosis) requiring continued institutionalization or constant supervision of the affected person.
7. Loss or diminution of vision to the extent that the affected individual has central visual acuity of no better than 20/200 in the better eye after best correction, or has an equivalent concentric contraction of his visual fields.
8. Permanent and total loss of speech.
9. Total deafness uncorrectible by a hearing aid.

Impairments which are remediable do not constitute a disability within the meaning of this section.

A person will be deemed not under a disability if, with reasonable effort and safety to himself, the impairment can be diminished to the extent that the individual will not be prevented by the impairment from engaging in any substantial gainful activity.

Claimants are referred to the state rehabilitation division for followup.

Available: School Health Examination Slides

MADISON—A series of 31 slides, showing all steps in school health examinations, is available through the State Medical Society.

The slides were originally prepared by Dr. E. H. Pawsat, Fond du Lac, and have attracted wide attention wherever shown. In 35mm color, the transparencies were designed particularly for showing to P. T. A. and similar organizations, to enlighten parents of proper procedures.

Dr. R. G. Welsch, Kenosha, also reported he has prepared a series of slides for the same purpose, and numerous requests have come to his office from service and educational groups in southeastern Wisconsin.

Dr. Davis Named To Division

MADISON—The Commission on State Departments announced recently it had appointed Dr. Jean P. Davis, Milwaukee, to the Division on Nervous and Mental Diseases.

Also appointed were Drs. R. A. Buckley, Eau Claire, and George H. Stevens, Wausau, to the Division on Maternal and Child Welfare.

Journal Advertising Wins Council OK

MADISON — Advertising of collection, credit and similar organizations in The Wisconsin Medical Journal was approved by the Council at its recent meeting, subject to the recommendation of the county medical society concerned in each instance.

Social Security Described As Levy, Not An Insurance

WASHINGTON—Social security is a tax, not an insurance program, Charles Schottland, Social Security Administrator, said at a meeting sponsored by the Social Legislation Information service recently.

Schottland said that Congress, through its power of taxation, calls the signals on the amount of levy and the amount of benefits to be given persons covered under social security. If any amendments are made this year, he said, the initiative is not likely to come from Health, Education and Welfare Department officials.

Questioning from the audience disclosed an interest in possible lowering of medical standards for determining disability under both the disability freeze and disability cash payment programs on the theory standards were too restrictive. The questions were described as interesting in light of S. S. A. figures released during the meeting on the number of denials for disability for failure to meet medical standards—80 per cent of the 320,000 who had failed to win certification. At the end of 1957, S. S. A. had made final determination on 690,000 of 1,000,000 who had applied; 370,000 had been certified.

Other social security highlights:

About 11,000,000 persons are now receiving monthly social security benefits; 65 per cent of all over 65 are drawing old-age and survivors' benefits, or will be able to draw them when their earnings decrease; by 1980, the proportion of aged population eligible for benefits will be 85 per cent, and by the year 2000, 94 per cent.

BALANCE MOUNTING

The Disability Trust Fund from which come payments to disabled persons, 50 or over, had a year-end balance of $640,000,000. By July, it will be slightly over $1,000,000,000.

The S. S. A. had underestimated both the number of women who would retire at 62 and self-employed farm operators who would come under the program as a result of the 1956 amendments, a development that put social security expenditures ahead of receipts earlier than anticipated.

COUNCIL SETS UP NEW SERVICE

MADISON — Establishment of a trial program of consultation service to hospital medical staffs as a postgraduate teaching mechanism was authorized by the Council of the State Medical Society recently.

The Council also set up a clearing house on information about scientific meetings within the state; invited members of the Wisconsin State Dental Society to attend scientific sessions at the Annual Meeting, and urged continued liasion with the University of Wisconsin Medical School to prevent its teaching programs from "starving for lack of teaching patients."

ASSISTANTS NAME MEETING SPEAKERS

MADISON—Two physicians practicing in the Elkhart Lake area will headline the speakers appearing at the fourth annual meeting of the Wisconsin State Medical Assistants Society in that resort city June 7–8.

Dr. John E. Martineau, Elkhart Lake, will speak on "Small Town Practice," and Dr. Lloyd J. Steffan, Plymouth, on "Public Health." Dr. Steffan is Plymouth city health officer.

Scheduled to serve as masters of ceremonies for the banquets are Drs. Daniel E. Dorchester, Sturgeon Bay, and Robert J. Samp, Madison.

Other speakers will include Thomas J. Doran, Madison, claims director for the State Medical Society; Helen Martin, Milwaukee, on the subject of ethical relations with drug firms; Oscar W. Gaarder, Madison, on "Your Public Relations," and Anthony J. Baron, supervisor of the Sheboygan County Welfare Department, on "The Role of the Public Welfare Department in Providing Medical Care."

Audrey Holtshopple, Janesville, assistants' president, said more than 200 members from all sections of Wisconsin are expected to attend the two-day session.

MAKE A NOTE!

The 117th Annual Meeting of the State Medical Society of Wisconsin will be held in Milwaukee May 6–7–8.

ANCILLARY POLICY . . .

(Continued from page 39)

lency. It is further objectionable in that publicizing such affiliation tends to at least indirectly constitute a 'puffing' of the physician's facilities in comparison to those of others who do not have such facilities or service in their immediate practice.

"It follows, then, that where there is no employment involved the sharing of a common waiting room, or in some other manner publicly associating one of limited skills with a physician and surgeon, are also improper. This constitutes an indirect violation of the same principle enunciated in the case of employed ancillary personnel."

On the S.M.S. Calendar

6– 8—ANNUAL MEETING, STATE MEDICAL SOCIETY, MILWAUKEE!

9–10—Medical Society Executives and Attorneys Conference, Chicago

14– —Claims Committee, SMS

26– —June 24 — World Health Organization Assembly meeting, Minneapolis

JUNE

4– —Claims Committee, SMS

23–28—AMA Meeting, San Francisco

23–27—Midwest Institute on Alcohol Studies, Madison

JULY

2– —Claims Committee, SMS

13– —Grievance Committee, SMS

14– —Committee on Coordination of Medical Services

18– —Foundation Museum Campaign luncheon

21– —Division on Maternal and Child Welfare and subcommittees, SMS

25–29—General Council, Land O'Lakes

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STATE MEDICAL SOCIETY OF WISCONSIN

Facts about WISCONSIN PHYSICIANS SERVICE

PREPARED BY THE COMMISSION ON MEDICAL CARE PLANS

Radiologic Coverage Growing

Starting in mid-March 1958 all new coverage provided by Wisconsin Physicians Service carries benefits for radiation therapy of proven malignancies other than those of the skin. The benefit is provided for professional services rendered and x-ray, radium or radioactive isotopes used in the treatment. Under the "A" and "B" programs of WPS the benefits will be provided on a scheduled basis. On the special service (no-fee-schedule) programs of Blue Shield the benefits will be provided on the basis of the reasonable charges of the physician up to the maximum of $1,000 or $10,000 as selected by the policyholder.

The expansion of coverage was authorized at a meeting of the Commission on Medical Care Plans, March 15–16. At the same time the Commission reviewed its entire program of radiologic benefits provided through the mechanism of Wisconsin Physicians Service.

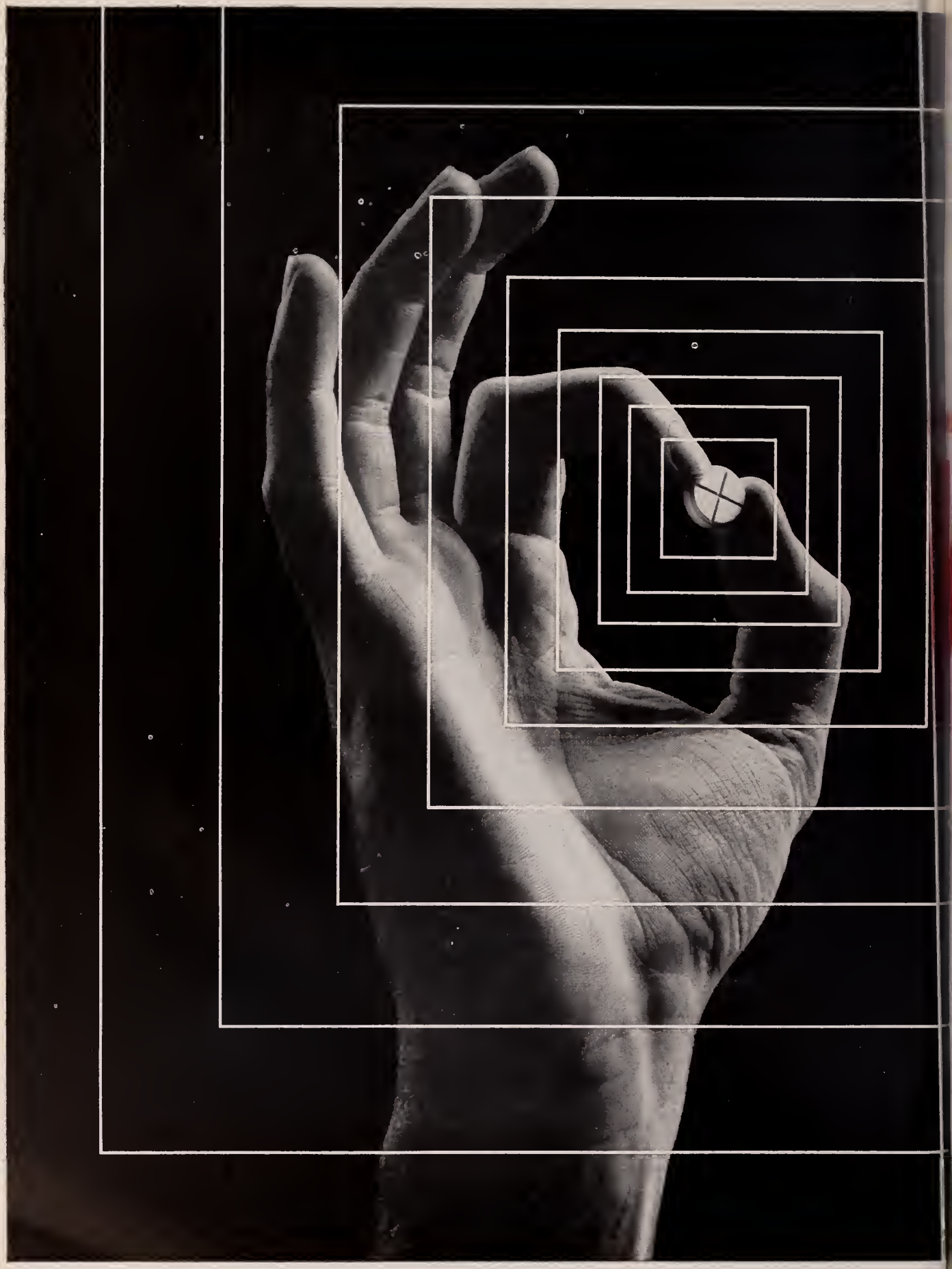
Benefits for diagnostic x-ray services associated with surgery or maternity are the minimum benefits provided each of the 350,000 persons covered by WPS Blue Shield. These benefits are provided according to the "A" and "B" fee schedules. More than 9,000 of Blue Shield's subscribers have purchased expanded diagnostic x-ray coverage for services in addition to those associated with surgery and maternity. Benefits are paid according to schedule and within a maximum of $50.00 or $100.00 as selected by the subscriber.

Another 20,000 of the 350,000 persons covered by WPS Blue Shield have diagnostic x-ray benefits on a reasonable charge basis for all x-rays except those associated with dental repair, pre-employment examination or the purchase of insurance. These are provided under special service contracts.

In the area of radiation therapy nearly 20,000 persons already covered under "A" and "B" contracts have purchased a rider providing scheduled benefits for the treatment of proven malignancies. Another 27,000 persons have radiation therapy coverage under special service contracts which provide benefits according to the reasonable charges up to the maximum of $1,000 or $10,000. Another 1,500 persons have coverage for radiation therapy through major illness contracts purchased before the advent of the special service coverage. These benefits are also provided on the basis of the reasonable charges of the physician.

For Information or Advice

Write: P. O. Box 1109, MADISON, WIS. *Phone:* ALpine 6–3101, MADISON, WIS.



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- Lowest Oral Dose In Sulfa History—0.5 Gm. (1 tablet) daily in the usual patient for maintenance of therapeutic blood levels
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- Convenience—the low dose of 0.5 Gm. (1 tablet) per day offers optimum convenience and acceptance to patients

NEW DOSAGE. The recommended adult dose is 1 Gm. (2 tablets or 4 teaspoonfuls of syrup) the first day, followed by 0.5 Gm. (1 tablet or 2 teaspoonfuls of syrup) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours. Dosage in children, according to weight; i.e., a 40 lb. child should receive ¼ of the adult dosage. It is recommended that these dosages not be exceeded.

TABLETS: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

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1. Nichols, R. L. and Finland, M.: *J. Clin. Med.* 49:410, 1957.

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Is she blue at breakfast? Prescribe BONADOXIN. Usually just one tablet at bedtime stops nausea and vomiting of pregnancy...

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MECLIZINE HCl . . . . . 25 mg.
PYRIDOXINE HCl . . . . . 50 mg.
Bottles of 25 and 100.

References: 1. Groskloss, H. H., et al: Clin. Med. 2:885 (Sept.) 1955. 2. Goldsmith, J. W.: Minnesota Med. 40:99 (Feb.) 1957.

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News Items and Personals*

Dr. Cauldwell Studies in Mexico

In February *Dr. E. W. Cauldwell* spent two weeks in Yucatan, Mexico, doing preliminary study of Mayan archeological sites on the northeast coast of Quiarana Roo and on the island of Cozumel. Doctor Cauldwell, a Beloit pathologist, also attended the South Central area meeting of the American College of Pathologists in New Orleans, Louisiana, during his trip.

Dr. Cunningham Opens New Office

Dr. Wilson Cunningham has remodeled the basement of his home into three rooms where he will receive patients. A life member of the State Medical Society, Doctor Cunningham has been practicing in Platteville, where his home is located, since 1900.

Dr. Nowack Leaves Watertown

On April 1 *Dr. L. W. Nowack* left his practice to go to Bowling Green University at Bowling Green, Ohio. He had been located in Watertown for a number of years.

* Physicians whose names are printed in italics are members of the Society.

Therapy Group Hears Dr. Larsen

"Shoulders" was the topic chosen by *Dr. Roy B. Larsen*, Wausau, when he addressed the Wausau Physical Therapy Group on January 23 at the Memorial Hospital. Doctor Larsen's talk was illustrated with slides and X-ray films.

Fox Lake Physicians Honored

The residents of Fox Lake paid tribute to *Dr. E. S. Elliott* at a testimonial dinner held in his honor on February 1. Having celebrated his fiftieth anniversary of practice in Fox Lake this year, Doctor Elliott was given recognition for his many years as a leader in the community both in his profession and in civic affairs.

New Coroner in Dodge County

It was recently announced that *Dr. Harold J. Heath* of Juneau has been named coroner of Dodge County. Doctor Heath has been practicing in Juneau for the past 30 years and is presently the physician for the Dodge County Home and Hospital.

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Dr. Newton Honored by Rotarians

Dr. J. E. Newton received the first annual Rotary "Outstanding Citizen" award in tribute to his 44 years of serving Hudson and the surrounding community. He was given a bronze plaque inscribed with these words: "Outstanding Citizen—J. E. Newton—For the gentle hand, the kind and reassuring word and the swift and accurate professional care for thousands of patients over the past 44 years and those yet to come, this plaque is presented with grateful and loving hearts."

Fredonia Doctor in New Clinic

An office in the new Northern Ozaukee Clinic Building is now occupied by *Dr. Philip Wallestad.* Having moved into the building on February 1, Doctor Wallestad is the first physician to use its facilities. It is anticipated that a dentist will locate in the remaining offices in the near future.

New Staff at Beloit Hospital

New medical staff officers were named by the Beloit Hospital staff members at the February meeting. They are: *Drs. D. M. Clark*, president; *William Fitzgerald*, president-elect, and *E. P. Onderak*, secretary-treasurer. Drs. Clark, Fitzgerald, *W. L. Cochrane*, *T. C. Sweeney* and *H. W. Kishpaugh* constitute the executive committee of the hospital.

Dr. Mulvaney Addresses PTA

A lecture on "Mental Health" with reference to what parents can do to maintain this state in their children was presented by *Dr. John Mulvaney* at the February 17 meeting of the Antigo Parent-Teacher Association. Doctor Mulvaney practices as a psychiatrist in Wausau.

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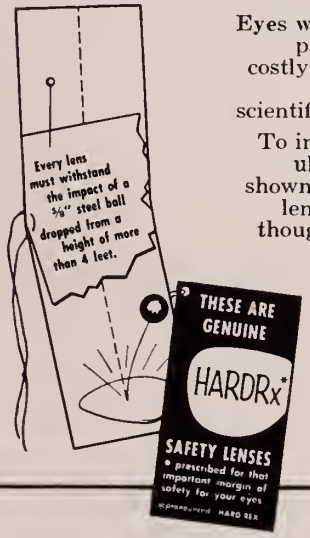

Eyes worth correcting are worth protecting. All of your patients *deserve* maximum safety from dangerous and costly lens breakage. Benson's HARDRx safety lenses – ground to a formula-determined thickness and scientifically heat-treated – are toughened to resist impact.

To impress on your patients that you've prescribed the ultimate in lenses for them, the identifying tag shown at left is attached to each pair of genuine HARDRx lenses. Your patients will appreciate your thoughtfulness in prescribing this extra protection . . . and will tell their friends of your quality service.

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Start therapy with one or two 500 mg. tablets of 'DIURIL' once or twice a day.

BENEFITS:

- The only orally effective nonmercurial agent with diuretic activity equivalent to that of the parenteral mercurials.
- Excellent for initiating diuresis and maintaining the edema-free state for prolonged periods.
- Promotes balanced excretion of sodium and chloride—without acidosis.

Any indication for diuresis is an indication for 'DIURIL':

Congestive heart failure of all degrees of severity; premenstrual syndrome (edema); edema and toxemia of pregnancy; renal edema—nephrosis; nephritis; cirrhosis with ascites; drug-induced edema. May be of value to relieve fluid retention complicating obesity.

SUPPLIED: 250 mg. and 500 mg. scored tablets 'DIURIL' (chlorothiazide); bottles of 100 and 1,000.

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HYPERTENSION

1 INITIATE 'DIURIL' THERAPY

'DIURIL' is given in a dosage range of from 250 mg. twice a day to 500 mg. three times a day.

2 ADJUST DOSAGE OF OTHER AGENTS

The dosage of other antihypertensive medication (reserpine, hydralazine, etc.) is adjusted as indicated by patient response. If the patient is established on a ganglionic blocking agent (e.g., 'INVERSINE') this should be continued, but the total daily dose should be *immediately* reduced by 25 to 50 per cent. This will reduce the serious side effects often observed with ganglionic blockade

3 ADJUST DOSAGE OF ALL MEDICATION

The patient must be frequently observed and careful adjustment of all agents should be made to determine optimal maintenance dosage.

BENEFITS:

- improves and simplifies the management of hypertension
- markedly enhances the effects of antihypertensive agents
- reduces dosage requirements for other antihypertensive agents—often below the level of distressing side effects
- smooths out blood pressure fluctuations

INDICATIONS: management of hypertension

Smooth, more trouble-free management of hypertension with 'DIURIL'

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for symptomatic relief and prevention of bacterial complication

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Supplied: Capsules, bottles of 36. Each capsule contains penicillin V, 62.5 mg. (100,000 units); salicylamide, 194 mg. promethazine hydrochloride, 6.25 mg.; phenacetin, 130 mg. mephentermine sulfate, 3 mg.

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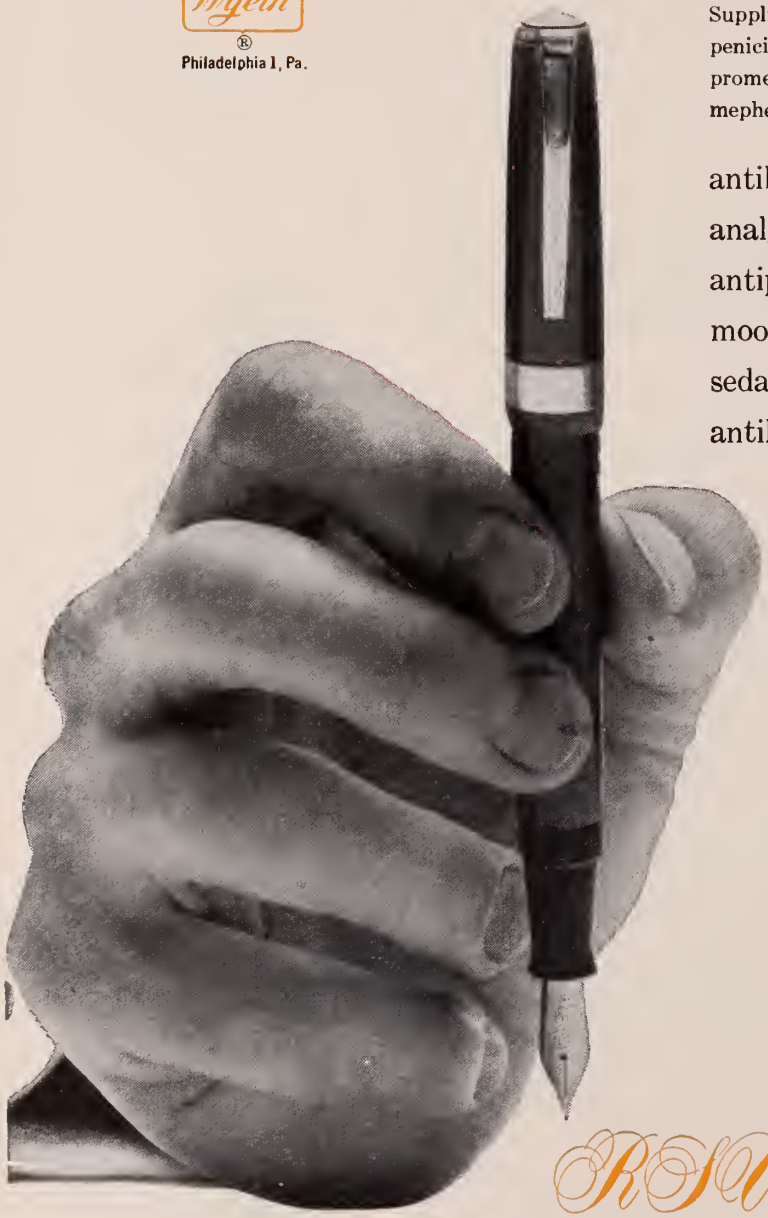

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This advertisement conforms to the Code for Advertising of the Physicians' Council for Information on Child Health.

Dr. Hildebrand Attends Meeting

A three day congress on industrial health held during January in Milwaukee was attended by *Dr. William Hildebrand* of Menasha. The program, designed to promote safer and more healthful conditions for employees of industry, was sponsored by the American Medical Association's Council on Industrial Health.

Dr. Smiles Speaks to Kiwanians

Dr. William Smiles of Ashland addressed the local Kiwanis group at a meeting held in January. Following a film pertaining to the heart and its functions, Doctor Smiles expanded on the important phases of the movie and answered several questions raised on the subject by the group.

Milwaukee Oto-Ophthalmic Society

On February 25 the Milwaukee Oto-Ophthalmic Society heard Dr. Harold F. Schuknecht, speak on "Vertigo and Deafness from Blows to the Head" at its meeting held at the University Club in Milwaukee. Doctor Schuknecht is the associate surgeon in the division of oto-laryngology at the Henry Ford Hospital in Detroit, Michigan.

Northeastern Wisconsin Chapter of GP

Main speaker at the January 30 meeting of the Northeastern Wisconsin Chapter of General Practice was Mr. Charles House of the Milwaukee Sentinel. The meeting was held at the Green Bay home of *Dr. Bernard Kulkoski* who assumed the office of president for the coming year. During the evening the following officers were elected: *Drs. S. F. Brusky*, president-elect; *Emmet Killeen*, vice-president; and *Clarence A. Rothe*, secretary-treasurer.

Milwaukee Academy of Medicine

The scientific portion of the Milwaukee Academy of Medicine was given by Dr. David Slight, director of the Veterans' Rehabilitation Center in Chicago, who presented a paper on "Public and Private Delusions". Members of the Milwaukee Neuropsychiatric Society and their guests were invited to attend this dinner meeting held February 18 at the University Club of Milwaukee.

Shell Lake Clinic Opens

Dr. L. O. Simenstad, Osceola, was the main speaker at the open house held in January at the new Shell Lake Clinic. *Dr. D. V. Moen* and *Dr. D. J. Welter* are co-owners of the building.

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General Surgery, Two Weeks, May 5; One Week, May 12
Breast & Thyroid Surgery, One Week, May 5
Fractures & Traumatic Surgery, One Week, June 9
American Board Review Course, Two Weeks, Fall of 1958

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, Two Weeks, June 2
Vaginal Approach to Pelvic Surgery, One Week, July 14
General & Surgical Obstetrics, Two Weeks, June 16

MEDICINE—General Review Course, Two Weeks, May 12
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Hematology, One Week, June 2
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PEDIATRICS—Two-Week Intensive Course, April 21
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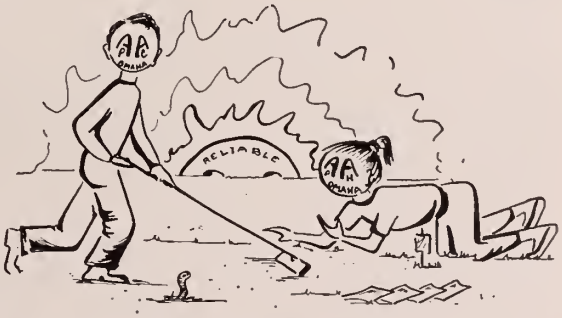

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New Doctor in La Crosse

Dr. Robert A. Pribek, an internist, is now associated with the La Crosse Clinic. Prior to locating in La Crosse, Doctor Pribek received his medical degree in 1953 from Marquette University School of Medicine, interned at St. Mary's Hospital, Duluth, Minnesota, and recently completed a three-year residency at the VA Hospital in Wood.

Doctor Gerol Lectures on Mental Health

A neuro-surgeon at the Monroe Clinic, *Dr. Yale Gerol*, was guest speaker for the February 24 meeting of the Green County Association for Mentally Retarded. The program was presented to encourage interest in providing special education for retarded children.

Panel Given on Peptic Ulcer

"The Diagnosis and Management of Peptic Ulcers" was the subject of a panel discussion presented by four Kenosha specialists on February 17. *Dr. John Garren*, surgeon, was moderator of the program during which color slides presented by *Dr. Stephen Holt* illustrated the pathological aspect. *Dr. William Swift* explained the radiologist's work in relation to this condition. Internist *Dr. James Duncan* described the diagnosis. The meeting was sponsored by the Kenosha Hospital Auxiliary.

Hobby of Physician Becomes Business

A hobby, fashioning images of human organs in plastic for tie clasps, cuff links, earrings and key chains, was started by *Dr. Robert G. Zach* during World War II and has now developed into a substantial enterprise. Because of the demand for these articles, he has organized the Medical Jewelry Company which employs nine persons. Doctor Zach is a radiologist at the Monroe Clinic.

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THIRD AND TWELFTH DISTRICTS NEWS

Dr. Turrell to Join Marquette Staff

It was recently announced that Dr. E. S. Turrell will assume the duties of Director of Psychiatric Services of the Milwaukee Sanitarium Foundation and Professor of Psychiatry at Marquette University School of Medicine on July 1. At present he is Associate Professor of Psychiatry at the University of Colorado School of Medicine.

Doctor Turrell will devote full-time services to the sanitarium and the medical school. He will be in direct charge of the medical care program at the sanitarium and will organize residency training programs in psychiatry at Marquette. It is anticipated that a coordination of the psychiatric residencies in Milwaukee will pave the way for development of intensified training programs in other M lwaukee hospitals. In addition, *Dr. John S. Hirschboeck*, Dean of the medical school, said this program, when developed, will help solve the shortage of psychiatrists in Milwaukee and elsewhere and supplement the overall teaching of psychiatry in the medical curriculum.

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Dr. Anderson Speaks

A Madison pediatrician, *Dr. R. B. Anderson*, addressed a group of parents of pre and grade school children at Madison in January. He discussed "Physical Maturity for the Child Entering School."

Dr. Messer Affiliated with Jackson Clinic

Dr. James W. Messer joined the staff of the Jackson Clinic, Madison, in January to practice internal medicine. He was a 1953 graduate of Johns Hopkins University School of Medicine and had been associated with the Mayo Clinic in Rochester, Minnesota, since 1954.

Conference Hears Madison Physician

The dangers of cancer quackery were enumerated by *Dr. Robert J. Samp* at the 16th Mid-Winter Occupational Safety Conference held in Milwaukee during January. Doctor Samp is a staff member of the Cancer Research Hospital of University Hospitals. Madison.

Visiting Professor at U. W.

Director of the Institute for the History of Medicine at the University of Frankfurt in Germany. Dr. Walter Artelt is lecturing on the history of medicine at the University of Wisconsin Medical School. With the arrival of Doctor Artelt as visiting professor, the course has again become activated.

Dr. Bowers Addresses Alumni

Dr. John Z. Bowers, Dean of the University of Wisconsin Medical School, delivered a speech on February 21 on "Modern Medicine and the University of Wisconsin." He appeared at the Wisconsin Alumni Association's Founders Day meeting which was held in Racine.

Dr. Crosley Studies in Colorado

With a view toward enlarging and improving the postgraduate courses offered by the University of Wisconsin Medical School, *Dr. A. P. Crosley, Jr.*, attended the program of Postgraduate Medical Education at the University of Colorado, Denver. Doctor Crosley is Chairman of the Postgraduate Course Committee at the University.

Dr. Gordon Speaks in Chicago

On March 7 *Dr. E. S. Gordon* spoke at the annual clinical conference of the Chicago Medical Society in Chicago, Illinois. Doctor Gordon, professor of medicine at the University of Wisconsin Medical School, chose the topic "Advancing Knowledge of the Nature of Atherosclerosis" for his talk.

MARRIAGES

Dorothy W. Campbell, Milwaukee, to *Dr. Roland A. Jefferson*, Milwaukee, February 17.

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OBITUARIES

Dr. E. L. Gilman died December 10 at the age of 73.

He was born at Greenbush on February 8, 1884. Doctor Gilman was graduated from the Milwaukee Medical College in 1911 and licensed to practice in Wisconsin the same year. He had been located in Mellen since that time, receiving the "Citizen of the Year" award from the local Lion's Club in recognition of his many years of continuous service.

Doctor Gilman is survived by his wife, Edith, a son and a daughter.

Dr. D. R. Peterson, 56, of Independence expired December 30.

A native of Independence, he was born in 1901. After graduating from Marquette University School of Medicine and completing an internship at St. Joseph's Hospital, Milwaukee, in 1930, Doctor Peterson became affiliated in practice at the Peterson Clinic, Independence, with his father, Dr. C. F. Peterson. From 1951 to 1953 he was located in Strum and moved to Black River Falls for a short time before returning to Independence after the death of his father.

Doctor Peterson was a member of the State Medical Society of Wisconsin, the American Medical Association, and the Trempealeau-Jackson-Buffalo County Medical Society, having served as president of that society for two terms.

He is survived by his wife, Elsie, and a son, Charles.

TAKE A LOOK AT
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Dr. J. D. McAtee, Tuscaloosa, Alabama, died suddenly January 26. He was 45 years of age.

He was born in Kentucky in 1912 and graduated from Rush Medical College in 1937. An internship at St. Francis Hospital, Evanston, Illinois, was completed by him the following year. Covington, Kentucky, Three Lakes, Milwaukee and Tuscaloosa are among locations where he practiced. He was planning to return to Wisconsin this spring to establish a practice in Neenah.

His wife, Genevieve, and a son survive.

Dr. J. C. Devine, Fond du Lac surgeon, died unexpectedly January 28 at his home. He was 56 years of age.

Doctor Devine was born in Fond du Lac in 1901 and attended medical school at Marquette University, receiving his degree in 1926. He interned at Milwaukee County Hospital and then entered upon a residency at Misericordia Hospital until 1928. He returned to Fond du Lac to begin practice and formed a clinic there with his brother, Dr. H. A. Devine, and two nephews, Drs. John C. and James C. McCullough.

He was a member of the State Medical Society of Wisconsin, the American Medical Association, the Fond du Lac County Medical Society, and the American College of Surgeons, and the International College of Surgeons. Doctor Devine was a past president and secretary of the county society. He was a former chief of staff of St. Agnes Hospital.

Survivors include his wife, Helen, and five children: Dr. J. C. Devine, Jr., a captain in the U. S. army medical corps stationed in Korea; John, Denver, Colorado; David, a student at Wisconsin State College, Oshkosh; Mrs. John Hauer and Jane, both of Fond du Lac.

Dr. G. C. Werner, Jr., 30, died February 2 in Indianapolis, Indiana.

Doctor Werner was born in 1927 at Kenosha. He received an M.D. degree from Marquette University School of Medicine in 1951 and at the time of his death was taking postgraduate work in radiology at the University of Indiana Medical Center. He served with the U. S. Army on two occasions—the first being from November, 1945 to September, 1946 during his premedical education and the other when he en-

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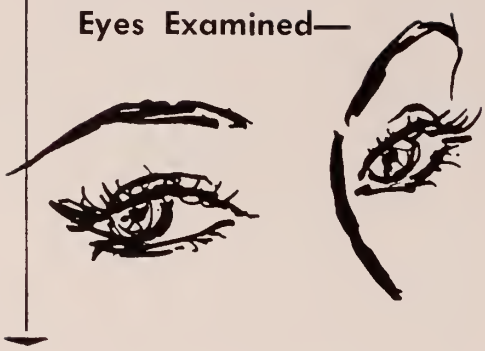

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listed in 1952. He was discharged in 1955 after receiving a Bronze Star for meritorious service in the Korean theater.

Surviving are his parents of Kenosha, a brother and a sister.

Dr. D. W. Roberts, a retired Milwaukee psychiatrist, passed away February 17 at the age of 73.

He was born in 1884 and was a 1911 graduate of the University of Arkansas Medical School. He also studied at the New York Neurological Institute. Prior to locating in Milwaukee, Doctor Roberts served a four year residency at the Arkansas State Hospital for Mental Diseases. During his active years in the medical profession, he was a professor of psychiatry at Marquette University and was a staff psychiatrist at the Sacred Heart Sanitarium.

Memberships included those with the Medical Society of Milwaukee County, the State Medical Society of Wisconsin and the American Medical Association. He was founder and first secretary-treasurer of the Milwaukee Neuropsychiatric Society, of which he was an honorary member.

Doctor Roberts is survived by his wife, Gladys, and two daughters, Mrs. Donald C. Booth, Whitefish Bay, and Mrs. George Wallace, Milwaukee.

Dr. A. L. Olson, a physician in Stoughton since 1915, passed away February 23. He was 81 years of age.

He was born in Stoughton in 1876 and graduated in 1911 from the University of Illinois Medical School. Before entering an internship at the Norwegian Deaconess Hospital in Chicago he worked as a proofreader for several papers. Entering practice at Crookston, Minnesota, Doctor Olson moved to Deerfield in 1907 and then to Stoughton. The doctor was a medical officer in Europe during World War I.

Among the survivors are his wife, Selma, and a daughter, Mrs. James Hayes, Arlington, Virginia.

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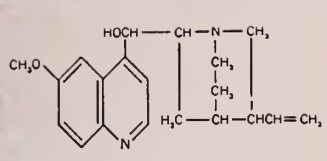

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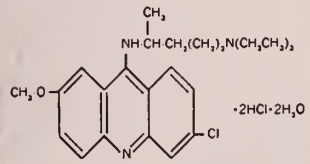

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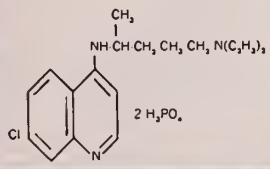

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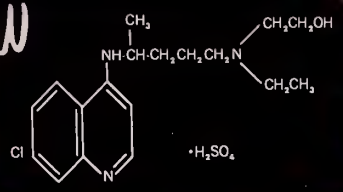

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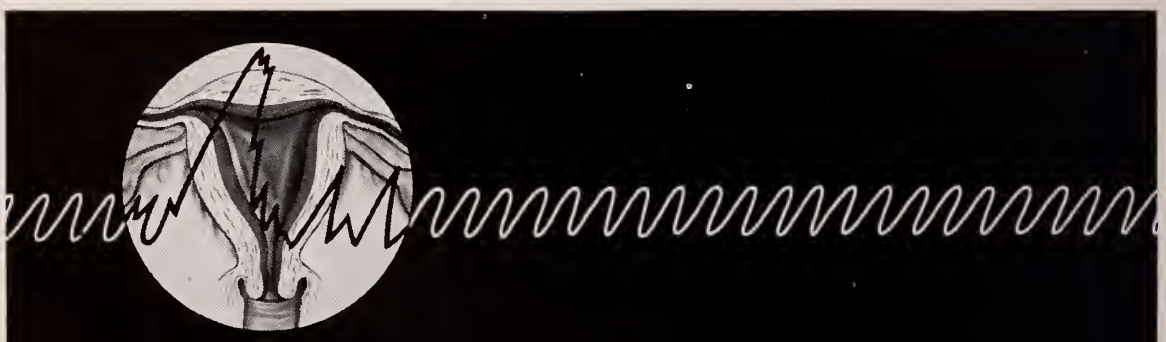

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1. Russek, H. I.: Postgrad. Med. *19*:562 (June) 1956.

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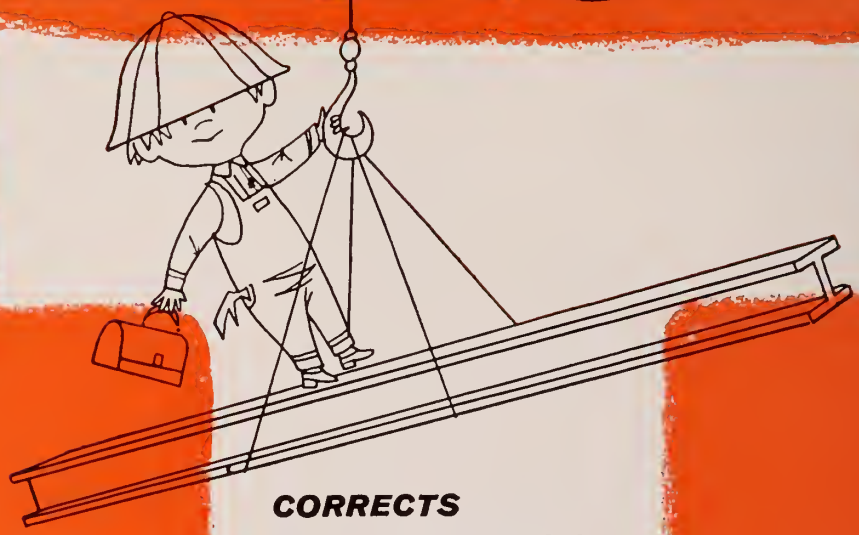

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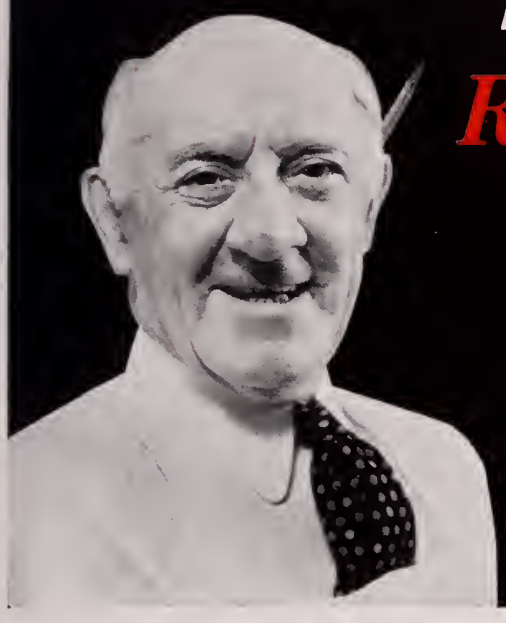

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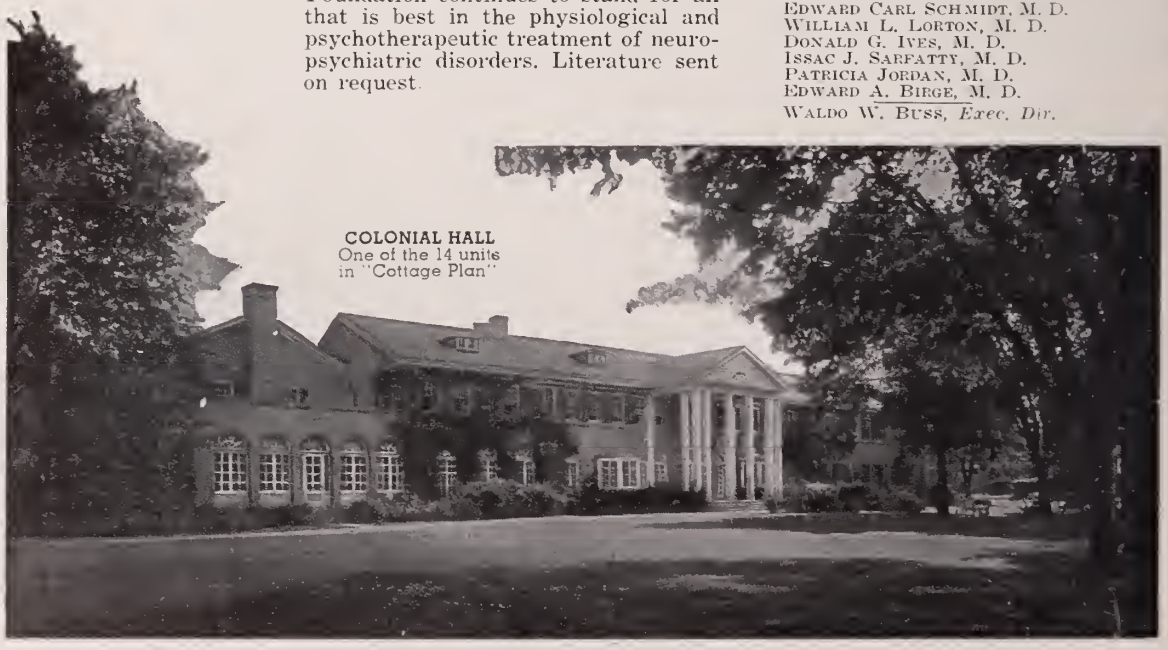

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Central Pain Syndrome

A Review of the Literature and a Case Report

By GERALD L. CLINTON, B. S., M. D.,* and MAX J. FOX, A. B., M. D.**

Denver, Colorado Milwaukee

CLINICAL PATTERN AND PATHOLOGY

DURING the last 65 years the literature has frequently contained reports and studies of a syndrome of spontaneous and paroxysmal pain associated with sensory impairment, and secondary to a lesion of the central nervous system. It has become apparent that the pathological nature and the location of the precipitating central nervous system lesion is extremely variable, as are the location and extent of the pain and the associated neurological findings. The first adequate study of central pain was by Dejerine and Roussy[1] who studied the effect of thrombosis of the thalamogeniculate artery with destruction of the posteriolateral nuclear mass.*** Interruption of the ascending sensory pathways by such a lesion results in the loss or gross impairment of all types of sensation on the opposite side of the body. Walker, in evaluation of their classical Thalamic Syndrome—syndrome of the thalamogeniculate artery—has listed the clinical features and discussed the pathology.[2]

1. *Fleeting hemiplegia or hemiparesis,* clearing in days or weeks, but usually there is a slight residual motor impairment. The reflexes may be slightly exaggerated, and slight hypertonicity may be present, but the paresis is essentially flaccid and true contractures do not develop. The Babinski response is rarely present. These signs are explained by deafferentation and transient edema of the internal capsule.

2. *Severe disturbances of superficial and deep sensibilities.* Complete hemianesthesia, most pronounced in the extremities and often sparing the face, is usually present initially. Superficial sensibility partially returns but deep sensation and stereognosis are usually permanently lost or markedly impaired. The sensation recovered is of two types: one, a vague, poorly localized sense of touch and, two, a disagreeable, unpleasant, irradiating sensation, usually to thermal or pain stimuli. Overreaction to such stimuli is commonly present and is so striking it has been named "thalamic hyperpathia." Thus stimulation, e.g., stroking the skin, passively flexing an extremity, warming or cooling the skin, or placing a tuning fork against a bony prominence, may not be appreciated in the usual manner but will evoke a response of intense displeasure, agonizing pain, or, in some cases, feelings of intense pleasure. The perception of any stimuli over the affected side is delayed as long as ten or more seconds.

The sensory changes described above have been related to destruction of the postventral portion of the thalamus and the terminations of the medial lemniscus and the spinothalamic tracts, and perhaps involving the pulvinar and the fiber tracts which pass between the nucleus ventralis posterior and the pulvinar.

3. *Intolerable pains in the affected side.* These are severe, persistent, and agonizing. The two types have been described: one, rheumatic pain, aggravated by joint motion and modified by the emotional state of the patient; two, "central" type of vague reference, often involving the entire affected side, and of variable nature. It is often described as burning, excruciating, crushing, tearing, grating, or boring; and it may be initiated or aggravated by cutaneous or deep stimulation. The latter type resembles thalamic hyperpathia; it, too, is not readily explained on the basis of the neurological lesion.

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*** Their nomenclature included the ventral thalamic nuclei as a part of the lateral nuclear mass.

4. *Disturbances of coordination,* e.g., ataxia, tremor, choreoathetoid movements, and, on rare occasions, hemiballism. These are explained by loss of proprioceptive sensations and involvement of the more anterior or inferior parts of the thalamus.

5. *Vasomotor and sympathetic disorders,* e.g., warm swelling of the affected extremities, skin and nail atrophy, and anisocoria —perhaps as a result of interruption of the afferent arm of a circuit operating through thalamohypothalamic relationships.

The above syndrome may be present in its entirety or may be partially represented, depending on the extent of the lesion.

In the years after the classic characterization of pain as a feature of thalamic lesions, many cases of overreactivity associated with sensory loss were described and lesions of the thalamus were often absent. The specificity of the syndrome as "thalamic" is thus questioned by cases with these findings produced by lesions of the cord, bulb, pons, midbrain, and cerebral hemispheres.

Cord—Kendall[3] describes a patient with pain over a limb and torso on one side, associated with a lesion of the lower cervical spinal cord. Foix, *et al.*,[4] and Spiller[5] present cases of intense pain in syringomyelia which could not be explained on the basis of posterior root irritation. Davison and Schick,[6] in a thorough review of the subject, report 9 cases in which cord lesions produced central pain.

Medulla—An interesting report is that of Foix[4] whose patient had burning pain on both sides of the face, right greater than left, with paroxysmal severe pain evoked by air currents or cold water touching the face. There was no objective sensory loss. Findings at necropsy were two small cavities occupying nearly symmetrical areas in the nuclei of the descending trigeminal tract in the medulla. Similar pain has been reported following bulbar trigeminal tractotomy and upper cervical anterolateral cordotomy.

Pons—Two of Kendall's cases[3] had central pain with pontobulbar glioma, and von Economo[7] presents a case in which the chest pain was severe enough to restrict breathing and in which the pain in the abdomen simulated colic. There was complete analgesia and thermoanesthesia on the right. At post mortem examination, a tuberculoma was confined to the left pons. Weisenburg and Stack[8] present two similar cases and Foerster[9] presents a case of central pain caused by a tuberculoma interrupting the medial lemniscus at the pontine level.

Cerebellum—A case thought to have been that of classical thalamic syndrome is described by Kozol.[10] Horrax and Popper, by excising the abnormal tissue lining a porencephalic cyst, brought relief of the pain. Davison and Schick[6,11] review reports of cerebral tumors causing central pain, and present two cases of pain secondary to ischemic lesions of the cerebral hemispheres which spared the thalamus. These were situated in the cortical and subcortical white matter in the parietal lobe and insula. One of these cases strongly suggested a thalamic lesion. Michelsen[12] describes 4 patients with neoplasm and one with cerebral trauma who had central pain; and, more recently, Critchley[13] adds to the list.

The specificity of the pain as thalamic is thus severely questioned, and we see that thalamic pain must be classified as a type of "central pain." The neurologic findings of the latter, of course, vary with the pathology. The clinical features are outlined by White and Sweet;[14] they form a clear-cut entity of—

(1) spontaneous constant pain,
(2) superimposed spontaneous or evoked paroxysms,
(3) increased pain threshold.
(4) The reference of the paroxysmal pain is over a wide area which may or may not include the area stimulated.
(5) Touch, heat, cold, and pinprick may all evoke the same diffuse, disagreeable sensation.
(6) There is often an increased period between the onset of effective stimulus and the sensation, which once evoked may then—
(7) long outlast the stimulus.

The subjective elements of this syndrome, i.e., spontaneous pain, paroxysmal pain, and sensory hyperpathia, seem to be the least common denominators of pain produced by central nervous system lesions.

ETIOLOGY

The cause of thalamic pain is not understood. The paradox of overreaction to stimuli in an area of diminished sensibility, and of paroxysmal and spontaneous pain in an area

of increased pain threshold, is as mysterious now as it was to Dejerine and his students. Another frustration to the investigators of central pain is that, in many cases, pathology identical with that producing pain will be manifest only in explicable components such as hemiplegia and hemianesthesia.

These difficulties have been properly recognized only in the most recent attempts to understand central pain. Earlier investigators hypothecated numerous mechanisms for pain production which are reviewed below for their historic significance.

Roussy[15] suggested that pain and hyperpathia are due to an irritation of the involved sensory structures. However, Head and Holmes[16] rejected this on the grounds that most cases of thalamic syndrome were due to vascular lesions which produce maximal effects immediately following the accident, while the pain of thalamic syndrome developed at a later time—perhaps after full recovery from the direct effect of the vascular lesion. With supporting cases, Head[17,18] proposed a type of release phenomenon in which the lateral part of the thalamus was thrown into hyperactivity by the interruption of inhibiting corticothalamic fibers. This theory was given credence as late as 1950 by investigators who proved the presence of such pathways.[19] The presence of cortical inhibition of thalamic activity has not been substantiated experimentally, [20,21] and it is well known that large lesions of the internal capsule do not result in thalamic pain.

Foerster[22] proposed a similar release of the thalamus from inhibition of the striopallidium. This theory ignores the fact that pain has not been shown to be present in pallidotomy or in striopallidal disease.

It has been mentioned that in central pain syndrome there is often a time disparity between the stimulus and the sensation. This observation led to the theory[9,23] that the phylogenetically young epicritic sensations—i.e., light touch, localization, two point discrimination, and moderate temperatures—inhibit the older protopathic type of high threshold sensations—i.e., pain and thermal extremes; disruption of the epicritic sensory pathways was thus the mechanism of the thalamic pain. Against this most interesting speculation is the fact that spontaneous pain can be present without disturbance of epicritic senses and that the fine, low-threshold senses have been eliminated without hyperpathia.[11,24–27] Central pain is not a common part of posterior column degeneration.

The fourth theory of interest is that the thalamus has a filter function, disturbance of which results in the conduction of impulses to the cerebral cortex that are normally retained by the thalamus.[28,29] However, it has been shown that pain impulses cannot pass the injured thalamus,[30] and Schuster[31] points out the absence of a proven neurophysiologic mechanism which facilitates conduction of impulses through injured gray matter.

A very significant paper is that of Spiegel and Wycis[32] who suggest that the hypothalamus may play a role in thalamic pain production. They note that thalamic pain may be elicited or increased by psychic influence, that the thalamic hyperpathia often has a strikingly affective character, and that pain description is usually overloaded with feeling tone. The vegetative nature of thalamic syndrome is well known and has even been compared with causalgia,[33] that thalamic syndrome is often associated with vasomotor and other vegetative disturbances has been noted.[28,29,31]

Spiegel and Wycis have shown that potentials evoked in the hypothalamus by stimulation of afferent nerves are enhanced by destruction of the posteroventral nucleus, and thus suggest that the entrance of pain conducting impulses into the hypothalamus plays an important role in the mechanism of thalamic syndrome.

The work of Weinstein[34] seems to add to the understanding of thalamic syndrome and the above theory. He observed 5 patients with classic thalamic syndrome and studied their general behavior and their premorbid personality, as well as their subjective and objective neurologic findings. As did Spiegel and Wycis,[32] he noted the unusual character of thalamic pain. His patients described it as "terrible," "awful," "something tearing me apart," "as if it's grabbing me in a vice," and "deadness;" on the mention of pain they would frequently groan and grimace. Paroxysms were produced by examiners stimulating or even talking about the paretic limbs, yet on occasion the patients could be turned and given other nursing care without pain. One of his patients would rub the affected limb while talking about pain in it, while such treatment by the examiner produced the usual painful reaction.

Investigation of the premorbid personality disclosed a consistent pattern of emotional instability, excitability, dependence, hypochondriasis, and chronic anxiety. He noted that the interpersonal family relationships were formed in material ways, in terms of physical affection and violence and in vocal rather than verbal expressions.

Weinstein feels that the objective complaints of his patients are the result of a process of integration, on a symbolic level, of much more undifferentiated perceptual elements. Thus, in the stress of illness or disability, the patient conceptualizes these elements in terms of his own interaction in the environment.

That the pathology of the thalamic syndrome involves the diffuse projection system is known. Involvement limited to these tracts has been found in patients with definite alterations in symbolic interaction in which pain is not present, e.g., anosognosia, inattention, pain asymbolia, and akinetic mutism.[35] It is but a short step to hypothecate that the pain, hyperpathia, and objective sensory complaints are likewise a selective symbolic expression of motivation. "Whether this expressed as a denial of the paralysis, as inattention to the affected side, or in terms of pain, seems to be closely related to the type of premorbid personality and the consequent nature of interpersonal relationships."[35]

The pathologic physiology is not known, but it is not suggested that disorders of symbol formation appear apart from an altered brain function.

THERAPY

In the past, those unfortunate enough to be victims of central pain were usually destined to drug addiction, vegetative withdrawal, institutionalization, and, frequently, suicide. The use of new medicines and surgical procedures has changed this black picture somewhat.

In 1951, Barris[36] reported the results of the use of diphenhydramine hydrochloride (Parke, Davis and Co.) in a series of 17 cases which fulfilled the criteria of (1) increased sensory threshold, (2) hyperpathia to thermal pain, or tactile stimulation, and (3) spontaneous pain. In daily dosage of 400 to 600 mg. of diphenhydramine hydrochloride (Parke, Davis and Co.), alleviation of pain and hyperpathia was judged good to fair in most cases and excellent in a few. The amenability to rehabilitative procedures was likewise increased.

Chlorpromazine has been useful in some cases. Margolis and Gianascol[37] present an interesting case of a 41-year-old female with initial regressing symptoms of right hemiplegia, aphasia, homonymous hemianopsia, and right hemianesthesia. Two weeks after the cerebrovascular accident she suffered the onset of burning pain over the affected side and in the succeeding nine months she became vegetative, made four suicide attempts, and was committed to an institution. The past medical history and the family history suggested neurotic conditioning of her response to the pain. Chlorpromazine, 200 to 400 mg. daily, brought dramatic relief of her symptoms, which recurred with placebo substitution.

Unfortunately this drug has been found to be of little or no value in other cases of thalamic pain.[38,39]

White and Sweet[14] have summarized the neurosurgical approaches to central pain; they classify the possible attacks in two categories as follows:

1. treatment at the primary afferent neurone, spinal cord, or post central cerebral cortex.[40,41]
2. treatment at the mesencephalon, thalamus, or frontal lobes.[14,42-45]

The results of the surgical approach have been occasionally gratifying, often good, but too frequently poor and unpredictable. Concerning the status of surgery, they feel that "the treatment of central pain is still in an evolutionary stage; no clear-cut recommendations are feasible from evidence at the present."[14]

PRESENTATION OF A CASE

On July 10, 1955, Mrs. J., a 39-year-old housewife from Milwaukee, sustained a bout of fever which responded to penicillin therapy. Ten days later while on vacation she suffered sudden onset of severe headache and lapsed into semi-coma which progressed to unconsciousness. She was observed in a northern Wisconsin hospital where a cerebrospinal fluid examination disclosed red blood cells. Her condition improved, but the headache remained and on August 1, 12 days after the ictus, suddenly became severe and was accompanied by right hemiplegia and motor aphasia. She again became comatose.

On August 2, carotid angiography performed in a Milwaukee hospital disclosed an aneurysm of the left internal carotid artery adjacent to its division into the anterior and middle cerebral arteries. The left common carotid artery was ligated by degrees with a Poppen clamp and occluded permanently on August 8 by Dr. Joseph Mufson (neurosurgeon).

The right hemiparesis cleared rapidly except for persistent weakness in the right arm and leg—most marked in the right thumb and index finger; the patient regained her ability to walk and speech improved greatly, but a mild aphasia remained.

In early September, pain, described as a throbbing, dull ache, appeared in the right half of the body. This pain was accentuated by sensory stimuli applied to the affected side, and was most severe in the right index finger. Pain persisted and became the chief complaint; many attempts to alleviate it with tranquilizers, analgesics, and sedatives, (including the use of diphenhydramine hydrochloride (Parke, Davis and Co.) were unsuccessful. Under chlorpromazine hydrochloride (Smith, Kline & French Lab.) dosage of 300 mg. per day, pain became more intense and constant.

During the first month of 1956, Mrs. J. was seen by several neurologists.[46,47] The findings on physical examination were as follows:

—an apprehensive lady whose blood pressure is 110/80. There is mild right hemiparesis with right lower facial weakness. The digits of the right hand are notably weak and attempt to exert full power was accompanied by a good deal of pain. No other motor findings were noted.

Perception of sensation over the right side of the body is impaired. Tactile stimulation is felt over the right but less than over the left, sensation being greatly impaired over the right hand, less impaired over the face, and least impaired over the right foot. Perception of pain (pin prick) and perception of temperature—especially heat—is impaired over the right side of the body; there is some decrease in vibratory and position sense and stereognosis is impaired in the right hand. Localization of stimuli is less accurate on the right side of the body than on the left.

There is a reaction of pain to any type of stimulus over the right side of the body; superficial and deep painful stimuli, passive motion, thermal and tactile stimuli produce paroxysms of diffuse pain.

Babinski reflex is present on the right.

Skull films showed a calcified pineal which was shifted to the left 4 mm.—interpreted as a shift toward the lesion representing a rather marked cerebral atrophy secondary to intracerebral hemorrhage. Pneumoencephalogram was not done.

In early June the spino-thalamic and the quinto-thalamic tracts on the left side were interrupted.[48] This procedure produced a hemihypalgesia without side effects. The dysesthesia that she experienced on stroking the skin was diminished while the deep, diffuse, spontaneous pain was present and unchanged.

The patient returned to Milwaukee where evaluation by the referring physician was that the patient was no better. Failure to alleviate the pain was explained by side paths in the reticulate substance and/or homolateral pain conduction. In lieu of enlargement of the surgical lesion, x-ray irradiation of the hypothalamus was suggested as a conservative technique.

In addition to her spontaneous pain, she now experienced generalized cephalalgia in an upright position and when she began to walk. This was thought to be due to traction on the basic lesion—the aneurysm.

In the following two months the patient became increasingly unresponsive; her continuing pain and vegetative state demanded a continuing effort on the part of the family to find relief.

In August, Mrs. J. was examined by a neurologist[49] who noted the midline division of her pain—front and back, and thereby concluded that the clinical picture was one of tremendous psychogenic overlay upon the organic pathology. A program of psychotherapy and an "all out push" type of physical and social stimulation resulted in increasing responsiveness and cooperation of the patient. Her speech improved greatly, she became tolerant of her subjective sensations, and the development of old and new interests gave promise that her remission would be permanent. At the time of this writing, eight months later, she has markedly improved.

DISCUSSION

The above case is almost identical with others described in the literature; it was thought by several eminent neurologists and neurosurgeons to represent a case of thalamic syndrome. How the thalamogeniculate artery could be selectively involved by a rupture of this aneurysm is difficult to understand, in the absence of atypical origin of the posterior cerebral artery. That her syndrome could be the result of intracerebral

hemorrhage and possible thrombotic occlusion of branches of the middle cerebral artery seems more likely. The sequelae of symptoms are certainly typical of "central pain syndrome." It is significant that pain and hyperpathia with secondary withdrawal which proved refractory to medical and surgical attack was brought into control by psychological means.

A careful evaluation of the patient's personality, background, and interpersonal reaction pattern is, of course, desirable. However, the information available and presented seems to support the concept that central pain syndrome involves psychological dynamics before unrecognized.

SUMMARY

The literature is reviewed, a case is reported, and a comprehensive list of references is presented. It is suggested that thalamic pain is part of a more inclusive category—central pain syndrome. Recent advances in the understanding of sensory projections and the symbolic aspects of perception give hope that the problem of central pain may eventually be understood and solved.

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(References continued on page 192)

Abnormal Hemoglobins

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Racine

THE subject of abnormal hemoglobins has been receiving considerable attention in recent years. The discoveries in this field have given us a better understanding of some of our hematological conditions. The actual mechanism of the cellular morphology found in some anemic states can now be explained and more intelligently classified. The discoveries have removed much of the guess work, as far as etiology is concerned, in some of our anemias. In addition, several new clinical entities have been found.

Fetal hemoglobin was first described in 1866.[1] In the newborn infant, fetal hemoglobin makes up 55% to 85% of the total hemoglobin. Within two years, 99% of the hemoglobin is of the adult type. Fetal hemoglobin is resistant to alkali, while adult hemoglobin is rapidly denatured by potassium hydroxide.[1] Fetal hemoglobin is abbreviated to "F" and adult hemoglobin to "A".

The next major milestone in the progress of this subject was the description of sickle cell anemia by Herrick in 1910.[2] He thought some physical or chemical condition of the blood was responsible for the sickling. This condition has been known to be hereditary since 1923.[3] It was thought to be due to a single dominant gene which might result in the sickle cell trait or in the sickle cell anemia. It was noted that the symptoms may be absent, mild, or severe. The degree of sickling corresponded with the severity of the disease. In 1947,[4] the trait was considered to be heterozygous and the sickle cell anemia was thought to be homozygous. The hypothesis was confirmed in 1949.[4,5]

In 1949, Pauling[5] discovered an abnormal hemoglobin in sickle cell anemia by means of electrophoretic mobility. This hemoglobin was called "S". The separation of protein fractions by paper electrophoresis is relatively simple. It can be performed by the average laboratory and has replaced the so-called albumin-globulin ratio. This new S hemoglobin can be identified by its viscosity, globulin content,[6] gel formation,[7] and also by its solubility and crystal structure,[8,9] in addition to its abnormal electrophoretic mobility. It also formed tactoids[7] and had a low solubility.[1] It solidified before it became completely deoxygenated. These findings adequately explained the reason the red cells sickled. Hemoglobin S, like A, was rapidly denatured by alkali.

The red cells do not sickle in vivo in the sickle cell trait. This is explained by the fact that the abnormal hemoglobin is associated with, and diluted by, normal hemoglobin which prevents sickling. In sickle cell anemia, most of the hemoglobin is of the abnormal S type which permits sickling.

The abnormal hemoglobin has been determined to be due to variations in the globin portion.[10]

Fetal hemoglobin is regularly present in sickle cell anemia, but not in the sickle cell trait.[11] Fetal hemoglobin persists indefinitely in certain chronic anemias which will be alluded to subsequently.[12]

Sickle cell disease is to be differentiated from sickle cell anemia. Sickle cell disease is caused by the interaction of the sickle cell gene with another abnormal gene such as the thalassemia gene. Such cases have been reported even before the discovery of the abnormal hemoglobins.[13] This means that a single abnormal gene might be modified by a second unrelated abnormal gene, so as to produce previously unexplained variants of sickle cell disease.

Another hemoglobin was discovered in 1950 by electrophoretic methods. It has a normal sensitivity to alkali. It was called hemoglobin "C". Hemoglobin C is present in about 2% of American Negroes. Hemoglobin C was shown to produce an asymptomatic trait in heterozygotes, and a fairly characteristic variant of sickle cell disease in combination with sickle cell gene.[14] It has been estimated that 15% to 20% of the cases previously classified as sickle cell anemia should now be classified as sickle cell hemoglobin C disease.[1] The homozygous state of hemo-

globin C showed some transient anemia with numerous target cells and splenomegaly, but no hypochromia.[15,16,17] An increased hemolytic process was demonstrated by the increased output of fecal urobilinogen. Arthritis was a major complaint in some cases. The diagnosis can only be made with certainty by electrophoresis. There was no fetal hemoglobin present. This means that some cases of sickling would require a genetic study.

The next hemoglobin was discovered in 1951. It was designated as "D".[18] This hemoglobin was electrophoretically indistinguishable from sickle cell hemoglobin, but showed a higher solubility and failed to sickle when combined with normal adult hemoglobin. This demonstrates that the separation of the hemoglobin proteins by electrophoresis alone is not sufficient to identify a hemoglobin component. Other physical chemical methods may be required.

Hemoglobin "E" was discovered in 1954. This hemoglobin resembled hemoglobin C on paper electrophoresis. However, the moving boundary method of electrophoretic study showed a discrepancy.[19] Hemoglobin "G" was also found in 1954.[20] The mobility or electrophoretic study corresponded to that of hemoglobin F, but there was no appreciable alkali-resistant fraction present, which is seen in hemoglobin F. Hemoglobin "H" was reported in 1955.[21] This occurred in a family of the colored race. A further hemoglobin was discovered in 1955 that was designated as "I".[22] This, too, was found in a Negro, along with normal adult hemoglobin. There were no abnormal hematological findings observed.

There are a number of hereditary anemias or traits involving the red cells such as congenital spherocytosis, ovalocytosis, and other conditions which apparently do not have a characteristic hemoglobin component.[23]

There is no known specific hemoglobin variant associated with thalassemia. The determination is on a morphologic basis and therefore subjective. There may be more than one thalassemia gene. Hemoglobin F is regularly associated with this condition. The quantity of hemoglobin F parallels the severity of the disease.[1] However, F occurs in other conditions and is not specific for thalassemia.

The clinical hematological characteristics resulting from the combination of these anemias or traits and the recently discovered hemoglobins, as well as anemias resulting from the interaction of abnormal hemoglobins, are now better understood because of these discoveries.

The sickle cell trait has a single sickling gene. The sickling hemoglobin is constant in an individual with the trait. It amounts to 22% to 45% of the total hemoglobin; the remainder of the hemoglobin is of the adult variety. The sickling in the trait occurs less rapidly and is non-filamentous in character. There is no anemia associated with the trait. However, splenic infarcts have been reported during high altitude flights.[24,25] The low oxygen content of the atmosphere would favor sickling, which in turn causes thrombosis and infarction.

Sickle cell anemia patients are homozygous. The hemoglobin is S alone, or in combination with varying amounts of F. Sickling occurs rapidly and in the filamentous form. It takes place in vivo and in dried blood films. Thread-like structures are seen in the bone marrow. This is not seen in the trait. Target cells are present, but there is no hypochromia. The disease has an early onset. The higher the S, the more severe the anemia. The patients have an asthenic habitus, they have arthralgia, and also bony changes. Abdominal crises may be present. The spleen is enlarged at first. Later it is small, due to infarction. When both parents have the trait, one-fourth of the children should develop the anemia.

The term sickle cell disease designates combinations of the sickling gene with other abnormal genes such as with hemoglobins C, D, G, or with a thalassemia gene. There may be more than one gene associated with the latter condition.

Individuals with the hemoglobin C trait are asymptomatic.[26] Twenty-five to 39% of the total hemoglobin is of the C variety; the remainder is of the A type. There is an increased number of target cells. Those that are homozygous have a mild anemia and splenomegaly. There are many target cells present.[15,16,17] Hemoglobin C may explain the target cell syndromes previously reported as Mediterranean anemia in the Negro. It can be differentiated from thalassemia by its electrophoretic pattern.

The hemoglobin C gene may combine with the sickling gene. In such instances the red cells show sickling,[15] up to 85% show target-

ing. The anemia is not as severe as in sickle cell anemia. The anemia tends to be more severe with pregnancy. Sudden unexplained death has occurred. This combination of genes may account for the atypical cases of sickle cell anemia or trait that have been seen in the past. A definite diagnosis can be established by electrophoresis.

Hemoglobin D has been encountered in association with adult hemoglobin as an asymptomatic trait and in association with hemoglobin S as a moderate hemolytic syndrome.[18]

Hemoglobin E is asymptomatic in the heterozygote individuals. In hemoglobin E disease, there may be anemia with normochromic target cells present and splenomegaly. There is a remarkable similarity between hemoglobins C and E.

Hemoglobin G was reported in 1954. It has the mobility, but not the alkali resistance of F.[20] The genetics and interaction of this gene are still not known.

Thalassemia minor is the heterozygous state for the thalassemia gene. The clinical picture is variable. Most cases show mild anemia with microcytosis and ovalocytosis.

Thalassemia major represents the homozygous state. The anemia is severe and progressive. It begins early and terminates fatally. Transfusions are helpful. There is splenomegaly and skeletal changes. The red cells show anisocytosis, microcytosis, ovalocytosis, normoblastemia, and hypochromia. There is an apparent block in the development of normal adult hemoglobin.

The thalassemia gene may be in combination with the sickling gene. The anemia resembles sickle cell anemia, but is usually milder,[15,23,27,28,29] The red cells show sickling, targeting, and hypochromia.

Thalassemia has also been associated with hemoglobin C disease. There are only two cases on record with this combination. There is one case in which thalassemia has associated with hemoglobin E.

SUMMARY

Our knowledge of abnormal hemoglobins has been greatly increased since 1949, when an abnormal hemoglobin associated with the sickling phenomenon was demonstrated electrophoretically. Various physical chemical methods besides electrophoresis are required to identify some of the abnormal hemoglobins. New clinical entities have been found that have fairly specific features. The reason for a disease state that resembles thalassemia in the colored race is now adequately explained. The combination of the sickling gene with other abnormal hemoglobins explains the so-called atypical cases of sickle cell anemia that were encountered. Many of the patients that were diagnosed as having sickle cell anemia actually had sickle cell disease. Other combinations of abnormal genes are known to exist. A review of some of the pertinent findings in these conditions has been presented.

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The following guides and manuals have been prepared at the direction of a number of councils, commissions, divisions, and committees of the State Medical Society to be of direct personal assistance to the physician or his county society. Each is available without cost upon request to the State Medical Society office, Box 1109, Madison 1, Wisconsin:

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15. **The Doctor's Role in Adoptions**—A reprint of three *Wisconsin Medical Journal* articles issued by the Division for Children and Youth, State Department of Public Welfare, Madison.

Are Public Health Services Meeting Present and Changing Needs?*

By JOHN D. PORTERFIELD, M. D.**
Washington, D. C.

ARE public health services meeting present and changing needs? I cannot answer that question for Wisconsin or any other individual state. But from the viewpoint of my personal experience with state and local health work and from the nation-wide view of the Public Health Service, I would have to respond "No." I doubt that any other answer could have been given at any other time or place in the whole history of public health. Even a hasty glance at speeches delivered at meetings such as this over the past 57 years supports that opinion.

Why are public health services always back of the eight-ball? It is too simple to say that they have always been understaffed and underfinanced, although both deficiencies are serious handicaps. We need to ask and answer a more searching question: Why do public health services lack adequate financial support and adequate well-qualified personnel?

It is also too simple to say that "science" has not presented public health services with effective techniques. To paraphrase a well-worn maxim, "Science helps them that help themselves." And it is distressing that so few public health organizations today engage in scientific research, even in their traditional fields.

At the risk of oversimplification, I would like to consider with you the following causes of our discontent:

—A lack of vision in the professions *and* the public of the role of public health services.

—Too close adherence to preconceived formulas for the organization and operation of public health programs.

—Too narrow a base of public representation in the planning and performance of public health activities.

"WITHOUT VISION THE PEOPLE PERISH"

That phrase seems to have been written for public health workers. People literally perish—are perishing—for lack of vision of their health needs.

There has been no lack of sound principles and broad, long-range goals in public health thinking. We have only to turn to the Report of the Sanitary Commission of Massachusetts, written in 1850 by Lemuel Shattuck, to find a statement of principles and goals that transcend anything we have accomplished so far.

"We believe that the conditions of perfect health, either public or personal, are seldom or never attained, though attainable;

—that the average length of human life may be very much extended, and its physical power greatly augmented;

—that in every year . . . thousands of lives are lost which might have been saved;

—that tens of thousands of cases of sickness occur, which might have been prevented;

—that a vast amount of unnecessarily impaired health, and physical debility exists among those not actually confined by sickness;

—that these preventable evils require an enormous expenditure and loss of money, and impose upon the people unnumbered and immeasurable calamities, pecuniary, social, physical, mental, and moral, which might be avoided;

—that means exist, within our reach, for their mitigation or removal;

—and that measures for prevention will effect infinitely more than remedies for the cure of disease." [1]

The average length of life has certainly been very much extended in the United States, but we can hardly claim that its physical power has been greatly augmented. The patients in nursing homes, mental hospitals, and private homes count among their numbers hundreds of thousands of men and women who have lived beyond their "life expectancy" in a state of medicated survival resembling in no way augmented physical power.

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* Address presented at opening general session, Wisconsin Association for Public Health, Madison, Wisconsin, June 12, 1957.

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The "means exist, within our reach" to save some 17 thousand lives lost each year to cervical cancer alone, through the cytologic test. This is but one of our many present opportunities to save life and prevent sickness. We are leaving almost untouched that "vast amount of unnecessarily impaired health and physical debility" existing among those not actually confined by sickness.

Health workers have stated repeatedly that the "enormous expenditure and loss of money" due to illness in our time total upwards of 20 billion dollars annually. However, we have made very little impact on the burden of major causes of sickness and death. Public health agencies, in fact, often seem reluctant to become involved in the mitigation of the "pecuniary, social, physical, mental, and moral" calamities that have their roots in major health problems of the day.

Relatively few public health agencies are engaged in cooperative programs with their public welfare agencies to reduce the economic and social costs of dependency due to chronic disease and aging. Some are active in helping to improve the social blight of substandard housing, but still far too few.

How many health departments are wholeheartedly involved in extending and improving restorative and rehabilitation services? Certainly, these are the best means within our reach for mitigating the physical and mental calamities of prolonged disability, the "number one" immediate public health problem of today.

How many health departments are actively engaged in programs for the mitigation of alcoholism? Drug addiction? Juvenile delinquency? Illegitimacy? Highway accidents? We don't use the term "moral" nowadays to characterize large social problems in which the most prominent symptom is personal disregard of laws and mores. Shattuck's generation did use that term and he would probably have included the problems I have mentioned, for he made specific recommendations on the responsibilities of local boards of health with respect to "intoxicating liquors," "haunts of dissipation," and care of "insane persons."

Shattuck said nothing in his fine prospectus of public health responsibility about communicable disease. In his recommendations he does charge boards of health with special, but by no means exclusive, responsibilities for "zymotic, epidemic, and contagious diseases." Shattuck did his creative thinking before the Bacterial Age of health science. Not a single "germ" had been identified as a cause of disease in his day. He also lived before the Age of Freud. So he was at liberty to look upon all disease, all ill health, all "moral evils" as the whole responsibility of public health, unhampered by our present limited vision.

Public health workers have been so preoccupied with applying Pasteur's "germ theory of disease" that we are barely beginning to apply our own unique scientific discipline—epidemiology—to the present major causes of death, illness, and physical debility. In the afterglow of our victories over communicable diseases, we have somehow—like a certain prewar prime minister—"missed the bus." Yet we are aggrieved when some other group or organization beats us to the bus stop, climbs aboard with an acceptable plan, and roars off with society toward the mitigation of some calamity which we have rejected as not within our province.

We feel aggrieved not only because no one likes to be beaten at his own game but also because we, too, feel rejected. And we are convinced that public health organizations possess qualifications that no other social institutions possess for dealing with community problems that involve disease or impaired health.

Public health organizations do indeed possess special qualifications. Their staffs include personnel with the basic skills—medical, nursing, engineering, technical, statistical, educational—which are required for the development of community programs. They possess methods for the organization and administration of certain kinds of service on a community-wide basis. They possess certain legal authorities that give them status in the community. And they possess, if they are worth their salt, more information on health problems and health resources than any other organization in the community.

If the professions and the public have a narrow view of how these qualifications are to be used, if there is no forward vision of public health responsibility, then, as new needs press sharp, society will ease its pain by creating new organizations, even though the same basic public health qualifications are required. And it is a bad time for com-

munity health when people in need of services have to deal with innumerable agencies.

To meet present and changing needs, we must have a renewal of vision, a new way of perceiving the health needs of the American people in their communities this year, next year, and on into the twenty-first century. Public health workers need especially a new perception of their professional approaches to health problems in a profoundly different society. In short, we need to see ourselves as the public sees us. Perhaps we will not like what we see. If so, it is up to us to change the way we look or help the public to change its view of us.

PRECONCEIVED FORMULAS

A public health organization often finds itself hampered by preconceived formulas adopted by society for its functions, its staffing, its financial resources, and its spheres of action. I say that these formulas are adopted by society because the public health agency is a unit in the structure of government. In a democratic form of government, the people make the decisions and adopt the formulas through their representatives.

However, public health formulas have been conceived, developed, and presented for adoption by the professions involved. Many of the formulas currently applied to the organization and operation of public health services were developed anywhere from 35 to 100 years ago. Most of them were developed prior to 1939—nearly twenty years ago. Some of them have stood the test of time and no doubt will continue to be applied successfully for an indefinite period. Yet few of them have been subjected to the test of critical appraisal, so we have very little objective evidence of their effectiveness as applied to all populations and social settings.

The economy of public health measures, for example, is one of our basic concepts. As stated and documented in the Shattuck report, however, it is a relative economy, to be compared with the estimated costs of premature death, preventable illness, prolonged disability, and dependency. "An ounce of prevention is worth a pound of cure." That is a familiar maxim to every public health worker. Somewhere along the line we have translated this truth into a hampering formula: that a public health measure must meet the criterion of "economy"—low cost—to be considered worthy of wide application. By extension, we have applied the same criterion to a program, a service, an oganization.

Perhaps we have oversold ourselves and the public on this low cost concept. We know that state and local health departments are often at a disadvantage in the competition for tax funds. Tax expenditures for hospitals and for public welfare, for example, are about five times the tax dollars spent for public health. State and local appropriations for public health services increased by 26 percent between 1952 and 1955. In the same period, state and local appropriations for roads increased by 38 percent, and for education by 44 percent. Dollar appropriations for those latter purposes were already several times higher than public health appropriations before these proportional increases occurred. In many states, the dollar increases could barely compensate for the higher costs of existing services and made no allowance for population growth or for new services in local communities. In the decade 1946 to 1956, the United States population increased by 20 percent; state and local public health personnel increased by only 6 percent.

Public health costs money. The changing needs of the present period cannot be met on the basis of old economic formulas. Some problems urgently require costly public health research in order to find new and less costly methods for their solution. Some problems can be attacked with means now within our reach—but these "means" cost money, too.

Community multiphasic screening programs in Richmond, Boston, and Indianapolis in 1950, for example, ranged in cost from $1.79 to $13.37 per person screened, depending upon the number and types of procedures applied and the number of persons screened.[2] The cost per new case discovered, of course, would be much higher. A home care program may cost from $25 or $30 to $375 per patient per year, depending on the number and types of services offered and on other factors.[3] The point I wish to drive home is that in a period of rising costs and complex problems, a cut-rate price tag will not attract adequate public support to meet changing health needs.

Staffing formulas can be equally restrictive. Very often the personnel requirements for a needed new service are based on formulas established years ago by the professions involved. These staffs were to deliver

quite different kinds of service to populations with very different standards of living. When first consideration must be given to meeting ironclad personnel formulas, there is little opportunity to develop more effective ways of using existing professional staffs, to recruit and train less costly auxiliary personnel, or to employ needed new specialists.

Of all the formulas that hamper public health services, the most restrictive and wasteful are the elaborate regulations and procedural requirements for the performance of routine tasks. All public health agencies have some regulatory functions established by law which make the drafting and enforcement of regulations essential. But in the exercise of these functions, the public health professions have carried over into many of their service programs a sort of regulatory approach, reducing *service* to an elaborate and over-detailed *procedural formula.*

All public health programs are based on law. No one would have it otherwise. However, many leaders in public affairs, politics, and the professions would be amazed at the legal and regulatory restrictions under which their public health services are developed and administered. I am aware, too, that Federal laws and regulations often place additional demands on state and local administration. However, we in the Public Health Service have observed, and have frequently been told, that the laws which we administer are less restrictive on state and local public health administration than are many state laws.

Experts in law and public administration are of the opinion that public health laws and regulations in many parts of the country could stand a basic overhauling. Revision and codification of laws is a complex and difficult problem, but progress in this area would surely lead to more efficient and economical operations. What is wanted, broadly, is a sufficient streamlining of laws and regulations so that, at the minimum, public health organizations may apply new scientific findings, as well as the principles of modern business management and public administration.

Preconceived formulas press most heavily upon local public health organizations. The full-time local public health service is one of the youngest local official agencies to come on the community scene. It is easy to forget that scarcely twenty years ago only about 800 counties had full-time local health services. Thus, by the time many of today's local health organizations were introduced, other full-time public services—schools, courts, law enforcement agencies, and so on—had long since been established and were fully integrated with the community's changing life. Their patterns of organization, goals, and daily operations were so thoroughly understood, so much a part of the community, that little or no sense of outside influences shaping those established services was felt by the people.

The classic full-time local public health service, however, was conceived and shaped "outside." And it brought into the community traditions, patterns, methods of operating, and formulas in the development of which neither the community nor the new organization's staff had had a hand. The staff was confronted by the further difficulty of adjusting, but not abandoning, its preconceived formulas to the community's traditions, patterns, and established formulas. Not infrequently, this meant that the new local public health organization had to find a *modus vivendi*, not only with competing official agencies, but also with several local voluntary health agencies, already well established in the community's esteem and affection.

Some local public health agencies continue to place major emphasis on another preconceived formula, the classic minimum "basic six" health services. Since the primary public health objective at the time the formula was developed was the control of communicable diseases, let us take a look at the period of its most intense application. The expansion of full-time local health services reached its peak, roughly, in the period 1940 to 1950. In the same period, the prevalence of communicable diseases—including such long-term infections as venereal diseases, tuberculosis, and malaria—catapulted downward, yielding to new methods of control or medical treatment and, undoubtedly, to wider application of these methods by the increased local agencies. So many local public health agencies established around the middle of this century on the basis of minimum service formulas found themselves at the dawn of the Antibiotic-Atomic Age, "all dressed up and no place to go." At least, they had not very far to go—in exclusive pursuit of rapidly vanishing communicable disease problems.

Every population needs some kind of organized protection against the spread of infections. The concept of surveillance and stand-by control mechanisms is gaining acceptance. Some populations need intensive, streamlined control programs for highly prevalent communicable diseases. This is a major need of our American Indians, for example, and it has the highest priority in the Indian Health Service. But it is unnecessary, unrealistic, and wasteful for local public health services in low-prevalence areas to devote a substantial share of their resources to routine control measures—waiting, as it were, for an epidemic or even a small outbreak to justify their existence.

Many a competent young health officer, trained in modern public health practice, along with his staff, suffers intensely in the strait jacket of preconceived formulas and outmoded regulations. He knows that many of the routine tasks are of questionable value; yet they are sufficiently time-consuming to absorb his limited resources. He may work, over and above the call of duty, to persuade community groups to engage in new, much-needed activities. But without enough staff, facilities, or funds to fulfill his department's obligations in such cooperative projects, he may get nothing for his effort but ulcers. Is it any wonder that such competent personnel often move on, not always to higher paid jobs but certainly to jobs where the administrative atmosphere is more propitious for modern health service, where they can practice public health in a manner closer to their ideals?

BEST FRIEND—SEVEREST CRITIC

If public health workers want to broaden their vision and society's vision, if they want to free themselves of their present restrictions, they will have to win the people of their communities as their best friends and severest critics. This is another way of saying that we must broaden the base of public representation in the planning and operation of public health programs.

To do so, we will have to crack our professional shells enough to let folks see that we are not "Rex Morgans" and "June Gales," supermen and superwomen whose word is law in the drama of sickness and threatened death. Instead, we are just ordinary folks with certain skills who would like to help people solve their community health problems. Yet the very professional traditions which a public health organization brings into a community seem to cast a mantle of mystery and impersonality about it. Its goals, its methods, its relationships with the people are not always understood, despite its earnest efforts at public education. Practically everybody in the average community is convinced that he could run the schools, the courts, the "welfare," the police, and the fire department as well as the incumbents—or better. Practically everybody tells you so. But when it comes to the local public health service, the average citizen assures you that he "doesn't know a thing about health"; he reckons "those fellows know their business."

For the health department, this uneasy acceptance can be a destroying booby trap. If the staff thinks the lack of forthright criticism is equivalent to a "Well done, thou good and faithful servant," they may never look critically at the community's needs and resources, but go on shuttling zealously back and forth in their accustomed grooves. If they mistake *diffidence* for *indifference*, they may feel defensive, called upon to press more insistently for their established programs. Or they may become as apathetic as they assume the public to be, choosing comfortable routines and hoping nobody will notice what's going on in public health.

Public health workers need to make sure that their contacts in the community are not confined to the rosters of their professional societies and lists of board members. The local medical society is the public health department's closest affiliated group, and the development of cordial and fruitful relationships with local practitioners must have the health officer's unceasing care. Obviously, also, working relationships with voluntary health agencies and other official organizations are basic to this operation. But these groups represent only a small segment of the whole community whose intelligent, hard-working cooperation local health services need.

The concept of public participation in health work gained some momentum before World War II, but not wide application. Since the war, the organization of local health committees or councils has increased. In many instances, however, these groups represent only the key organizations in the health, education, and welfare fields, with few or no leaders of other sectors.

During the war, the mobilization of neighborhoods for civil defense and other purposes amply demonstrated the abilities of the natural leaders and members of the average neighborhood to conduct community programs. Public health services have scarcely tapped this powerful resource for community health.

Here are a few things that neighborhood people, just "ordinary" neighbors, accomplished at the behest of health agencies between 1935 and 1945. They brought in whole neighborhoods for chest x-rays at conveniently located case-finding stations, caused the diphtheria immunization of 100 percent of the child population under 10 years of age, cleaned up an entire city in a neighborhood sanitation campaign, and turned moribund prenatal and well-baby clinics into thriving health maintenance services.

Is there any reason why such groups couldn't perform as well, or even better, in meaningful programs for health of the aging, chronic disease control, and accident prevention? I think not. It will not be enough, however, to ask them merely to pass the hat in fund-raising campaigns or to rubber-stamp preconceived plans and budgets. Health agencies will drain public participation of its potential effect if they do not give their citizen collaborators a share in the planning and some duties to perform that have real health significance.

The public is much better informed and has a much more mature interest in health matters than the public of 50 years ago. Let's not miss this superb opportunity to make of every citizen a best friend and severest critic, for such friends can be depended upon in the life of an agency as well as in the lives of individuals.

CONCLUSION

The present and changing health needs in our changing society are not being met—but they can be met. Change in our public health services is a constant factor. At the present time, social changes are occurring so rapidly that long-established organizations may creak a little in trying to respond. Writing a few years ago, Lionel Trilling commented on the great changes now engulfing the world: "If the changes are not made in the direction of greater liberality, the direction forward, they will almost of necessity be made in the direction backward, of a terrible social niggardliness."[4]

If present and changing needs are to be met, public health services must be guarded against the niggardliness of narrow vision and ironclad formulas, and against its corollary, niggardly support by society. It is not enough to *want* the direction of public health to be forward. We must *work for it* with intelligence, with patience, and with renewed faith in its place in society.

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3. A study of selected home care programs. PHS Publication No. 447, GPO, Washington, 1955, (Monograph series No. 35).
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To Members of the Wisconsin Surgical Society . . .

An evening program will be held Thursday, May 8, in the Milano Room, Milwaukee Athletic Club, starting with cocktails at 6:00 p.m. The speaker will be Mark M. Ravitch, M.D., Baltimore, Md., Associate Professor of Surgery, John Hopkins University School of Medicine. The meeting will be open to members of the Wisconsin Surgical Society only, and their wives.

Reservations: James M. Sullivan, M.D., 161 West Wisconsin avenue, Milwaukee 3.

PHYSICIANS EXEMPT FROM JURY DUTY

You don't have to serve as a juror unless you want to. All practicing physicians, surgeons, and dentists are exempt. This doesn't mean that you are disqualified from jury duty. The exemption is a personal privilege which you may claim or waive as you wish.

If you are called to act as a juryman and wish to take advantage of your exemption, appear in court when called and state the cause of your exemption to the presiding judge.

Reference: *Section 255.02 (2), Wisconsin Statutes, 1957.*

Wisconsin Anesthesia Study Commission of the Wisconsin Society of Anesthesiologists

Editor—DOROTHY W. BETLACH, M. D., Janesville, Wisconsin

Crush Syndrome

During the administration of an anesthetic, the anesthesiologist must be concerned with the general welfare of the patient as well as the course of the anesthesia. This continuous observation is necessary to prevent untoward complications not related to the physiologic disturbances from any drug administration or surgical procedure. The Wisconsin Anesthesia Study Commission presents an unusual case in which the necessary positioning of the patient resulted in unexpected injury with rare complications.

Case No. 79.—A 26-year-old white male entered the hospital for evaluation of a rather severe exertional dyspnea of 20 months duration. Since childhood, he had had a heart murmur but he never had demonstrated any symptoms or cyanosis. Cardiac catheterization revealed an interatrial septal defect and a Sondargaard closure of the defect was proposed.

The patient was a well-developed, muscular white male weighing 180 pounds. Hemoglobin was 18.1 gm., non-protein nitrogen was 31 mg.%, and blood pressure was 130/80. There were no preoperative complications. Endotracheal anesthesia was conducted without incident throughout the seven hour procedure. During this time the patient was in the left lateral decubitus position on the table. His position was checked several times to be certain there were no rumpled sheets beneath the patient. During the operation, 1,000 cc. of blood were given, and the patient was responding at the end of the procedure.

In the recovery room, a very hard, indurated, whitish area with a sharply circumscribed margin was noticed over the left deltoid muscle. This area resembled a furuncle and was treated with warm compresses. The immediate postoperative course was satisfactory. On the first postoperative day, the left shoulder and left arm had become more edematous and indurated as was the patient's left side and hip. On the third postoperative day, the induration of the left arm was increased markedly and the patient had become oliguric. Hemoglobin determination was 11.1 gm. and the non-protein nitrogen was 182 mg.%. Since there was no apparent obstruction of the lower urinary tract, it was believed his kidneys had ceased to function due to a lower nephron nephrosis. Therapy was directed toward maintaining electrolytic balance and limiting fluids.

During the ensuing five days, the patient continued to be oliguric and he became mentally confused. The non-protein nitrogen rose steadily to 221 mg.% and creatinine to 22 mg.%. Examination of the chest revealed no abnormalities except for some fluid accumulation at the right base. The patient died suddenly on the seventh postoperative day after complaining of severe pain in the right side of his chest and the right upper abdomen.

At postmortem examination a large amount of blood was in the right pleural space, although no source of the hemorrhage was found. The actual closure of the heart and the correction of the atrial septal defect were intact. There was gross and microscopic evidence of severe lower nephron nephrosis bilaterally. Microscopic sections of the deltoid muscle of the left arm showed edema, distortion, and disintegration of the myofibrillar pattern. It was the pathologist's opinion that the cause of death probably was due to the absorption of toxic products from the arm muscle resulting in chemical lower nephron nephrosis or hemoglobinuric nephrosis.*

DISCUSSION

With the improvement in anesthesia care, lengthy operations for complex procedures will be more routine and the occurrence of such complications will increase. The large, well-developed individual who had good firm, muscular tissue compressed and immobile for any length of time, seems to demonstrate this type of injury more readily than elderly,

cachectic patients. Precautions should include the avoidance of rumpled sheets or clothing beneath pressure points such as shoulders, hips, and knees; shortening of operating time as much as is feasible; and prevention of additional weight on the patient from surgeons' arms and heavy instruments. Special mattresses composed of multiple, separate layers of 1½ inch thick foam rubber may help equalize pressure distribution.

"Lower nephron nephrosis," "hemoglobinuric nephrosis," and "crush syndrome" are terms applied to a rather typical kidney lesion found in patients who die from various causes, most important of which are severe injuries, especially of the crushing type, burns, blood transfusion, and sulfonamide intoxication.[1] Similar pathology has been observed in cases of heat stroke, toxemias of pregnancy, uteroplacental damage, shock, and severe infections.[2,3] During World War II, British pathologists described this distinctive lesion of the kidney in patients who died of severe injuries associated with ischemia and crushing of muscle.[4]

The outstanding features of the kidney lesion are marked, random degeneration of the distal convoluted tubules and a deposition of red-brown granular material. This is followed by renal ischemia and acute renal failure.[5] Muscle sarcoplasm contains a protein, myohemoglobin. Ordinarily, this protein is not found free in the blood plasma or the urine. Under unusual circumstances, however, myohemoglobin may be released from the muscle with rapid appearance in the urine as brown crystals. Overload of the kidneys occurs.[6] It has not been shown clearly whether the substance seen in the kidney tubules in lower nephron nephrosis is toxic or whether the ischemia is due to mechanical obstruction even though there is no dilatation of the proximal tubules.[2] Some observers believe that the likelihood of renal damage is enhanced by shock, dehydration, or reduction in blood volume associated with the injury or disease.[3]

Clinically, the patient may appear in good condition at first and then show the sudden development of proteinuria and oliguria or anuria. The mortality rate is very high, about 90%, while the average interval from the time of injury or illness to death is about ten days.

Advances in anesthesia and surgery may bring new complications. Every member of the operating room staff must be cognizant of the possibility.

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* Case Report—"Crush Phenomenon" Anesthesiology, Vol. 18, No. 2, p. 342, March-April, 1957.

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TB Panel Presented in Beloit

The Beloit Welfare Council heard a panel comprised of *Drs. George Peterson, Thomas Sweeney, E. A. Cornelius* and *H. A. Raube* discuss tuberculosis control programs available for the protection of residents in the Beloit area. The city health officer, *Dr. J. C. Springberg*, was moderator. The panel pointed out the importance of emphasizing such programs since Wisconsin's 1956 total of reported TB cases was the highest since 1951 and cases have not decreased greatly in number in the last 37 years. A talk given by *Dr. James M. Wilkie*, consultant to the Pinehurst Sanatorium, on "The Modern Interpretation of Tuberculosis Control," completed the meeting.

Dr. Larson Accepts New Positions

Dr. Frank C. Larson, Department of Medicine at the University of Wisconsin Medical School, has accepted the appointment as Director of the Clinical Laboratories of the University Hospitals and as Director of the program in Clinical Pathology for the Medical School. Dr. Larson will assume the new positions July 1 upon the retirement of *Dr. W. D. Stovall* from these responsibilities. He will also continue as a member of the Department of Medicine.

Dr. Schott Moves to Michigan

Dr. O. J. Schott, who has practiced in Gays Mills for many years, has moved to Lansing, Michigan. He has remodeled a large residence there and has opened his practice.

Clinicopathologic Conference

Sponsored by the Section on Pathology, State Medical Society of Wisconsin
Guest Editor: D. M. Angevine, M. D.

HISTORY *

A 55-year-old white female entered this hospital with a history of onset of pain (one year prior to admission) that encircled the thorax at a level just below the breasts. One month later she noted numbness of the left leg and trunk. This was followed by flexor spasms involving all four extremities. Although investigative studies at this time were negative, she received a course of deep x-ray and physiotherapy that led to some improvement in the function of the right arm. She had an indwelling catheter for the 10 months prior to admission because of the occurrence of extremely painful bladder spasms. Six weeks prior to admission an erythematous bullous eruption of the right arm, the back of the neck, and the face developed. This cleared several days after stopping all medication. Four days prior to admission to this hospital erythema of the face was noted following a butterfly distribution. Two days prior to admission she began to complain of chills, fever, and pain in the flanks, but there were no urinary findings. Her past history revealed that she had had erythema nodosum in 1931, and pyelitis for many years that finally responded to terramycin therapy.

PHYSICAL EXAMINATION

Physical examination on admission revealed a pulse of 120, respirations 24, and blood pressure 90/54 in a moderately obese white female who appeared her stated age and looked acutely and chronically ill. Marked flexor spasm of the extremity was evident; erythematous areas were noted over the face following the butterfly distribution; and there was erythema of the dorsum of the hands, the extensor surfaces of the arms, and over the left shoulder, with the forearms being involved in a patchy fashion. The pupils were round and equal and the funduscopic examination was negative. The nasal mucosa was injected and there was a mucoserous discharge, while the tongue was coated and the pharynx clear. Flexion of the neck was very limited but this apparently was not interpreted by the initial examiners as rigidity. Examination of the chest revealed decreased resonance to percussion at the lung bases and there were fine crepitant rales over the right lower lobe posteriorly. There was no evidence of cardiac enlargement and no murmurs were noted. There was tenderness in the right upper and right lower quadrants but the spleen and liver were not palpable. The abdominal muscles were rigid but no abdominal masses were palpated. The right leg was held in a fixed position with maximum flexion and the left leg was flexed at the knee. She had minimal motion in the left arm but there was flexion at the wrist and the fingers. Sensory perception was impaired, but a segmental level could not be determined. The left shoulder area revealed a loss of light touch and pain. A positive Babinski was noted bilaterally.

LABORATORY STUDIES

Laboratory studies on admission revealed the urinalysis with a specific gravity of 1.010, alkaline reaction, .05% albumin, negative reaction for glucose and acetone, 1 to 2 white blood cells per high power field, 2 red blood cells per 10 high power field, and no casts. The hemoglobin was 11.8 gm.% with a 3,400,000 red blood cell count per cubic mm. The white blood cell count was 15,100 with 77% neutrophiles, 3% band cells, 11% lymphocytes, and 9% monocytes. The sedimentation rate on correction was 41 mm. per hour with a hematocrit of 35. The fasting blood sugar was 107 mEq./l. and the nonprotein nitrogen 25. A spinal puncture revealed crystal clear fluid with normal pressure and dynamics. The chemistries including a Wassermann and gold sol curve were all normal. Numerous lupus erythematosus preparations were negative. A skin biopsy of the neck area revealed some edema of the dermis and perivascular cuffing. A urine culture on admission revealed coli aerogenes and enterococcis. These organisms persisted in her urine throughout her hospitalization.

* From University Hospitals, Madison, Wisconsin.

Proteus organisms were also found in the urine on several occasions. Three blood cultures revealed the enterococci and coli aerogenes. A recumbent chest x-ray was negative. X-ray of the legs revealed moderate osteoporosis and muscle atrophy without definite evidence of arthritis. X-rays of the right kidney revealed a large staghorn-type calculus forming a partial cast at the right kidney pelvis and calyces. A left retrograde pyelogram was normal. Spine films only revealed osteoporosis.

COURSE

While in the hospital the patient was given courses of ACTH and steroid therapy as well as antibiotics and long term physiotherapy. She had three acute episodes of renal colic, one of which required left ureteral catheterization to provide relief. There was one episode of phlebothrombosis of the left leg that required anticoagulant therapy. Throughout most of her hospitalization she remained an invalid. On the eleventh month of hospitalization she had developed a severe episode of renal colic with high fever and oliguria. Her temperature eventually returned to normal but sensorium remained cloudy with constant irrational complaining. An area of induration in the right buttock developed, presumably at the site of her previous terramycin injections. This area eventually became fluctuant and had to be incised, producing drainage of a large amount of brown, foul smelling, necrotic material. This left an excavation in the buttock that rapidly became covered by yellow exudate and never healed. The patient continued to cry and moan intermittently and it was necessary to feed her by stomach tube. She expired suddenly during her twelfth month of hospitalization.

Dr. Manucher Javid: There are a number of points of information that are not covered in this protocol. One should have all the pertinent data in order to reach a diagnosis. Since this is not available, we can, at best, review the information that is given and from that draw a conclusion. Reviewing the protocol of this 55-year-old lady, it would seem that the original impression of the physicians who cared for her was an inoperable lesion of the cord. Her chest pain might have suggested to them root irritation from a space-taking lesion. Flexor spasm is due to transverse involvement of the cord. It is unusual that, in view of this, her sensory findings were limited to numbness of the left leg and trunk. No information is given as to whether a myelogram was performed, but in view of "negative investigative studies" the indication for deep x-ray therapy is not clear. Considering the subsequent course, it would seem that improvement in the function of the right arm was not related to x-ray therapy. The remainder of the history is typical for lupus erythematosus eruptions. Whether she had similar lesions a year before is not known.

A review of the physical examination shows that this patient looked very ill. She had typical erythemas of lupus erythematosus. Her funduscopic examination was negative, although in advanced cases perivascular hemorrhages, segmentation of arteries and scattered exudates are often seen in lupus erythematosus. She had some pulmonary involvement. Her abdominal tenderness might have been due to peritoneal serositis seen in lupus erythematosus. Paraplegia in flexion usually means complete transverse lesion and is most commonly seen in trauma and infectious myelitis and vascular lesions of the spinal cord, but can occur in other conditions. She also had marked motor impairment of the left upper extremity and apparently no weakness in the right upper extremity. No information is given regarding the diaphragm and intercostal muscles. It is very difficult to evaluate her sensory picture from this protocol. The only information we have is that "sensory perception was impaired, but a segmental level could not be determined. The left shoulder area revealed a loss of light touch and pain." It would be extremely important to know whether all sensory modalities were carefully tested or not. The information is very inadequate. What is meant by sensory perception? "The anesthesia in the right shoulder," again the extent is not clear. Was the whole shoulder involved or was it the anterior or the posterior part of it? Depending upon the answer to this question, there might be cervical involvement from C5–C8. This patient had involvement of corticospinal tracts bilaterally, manifesting itself in positive Babinski reflexes, but no information is given regarding deep tendon and abdominal reflexes.

In reviewing the laboratory studies, the urine showed a trace of albumin. She had leukocytosis as far as this reading is concerned, but it would be important to know whether all white blood cell determinations

were high. Marked elevation of the sedimentation rate was in all probability due to lupus erythematosus. It could also have been due to elevation of white blood cells. Her hematocrit was low. Negative lupus erythematosus preparations do not rule out lupus erythematosus. Of course, lupus erythematosus cells may be seen in other conditions, such as multiple myeloma and rheumatoid arthritis. Skin biopsy findings could be explained on the basis of lupus erythematosus. Positive urine and blood cultures may well be due to secondary infection from lupus erythematosus. The patient also had a kidney stone. Her course in the hospital was progressively downhill with three renal colics, phlebothrombosis of the left leg, and development of an abscess in the buttock. She died after 12 months of hospitalization.

Differential Diagnosis: Anatomically, I would place this lesion in the cervicothoracic cord with maximum involvement in the lower cervical segments, right greater than left, as indicated by clinical evidence of damage. How many segments are involved below this level? I don't think it can be determined clinically. Without question, this patient had lupus erythematosus. The important question is whether her central nervous system findings were due to this disease or some other disorders. I am going to reverse what might be considered standard procedure by first giving the pathological diagnosis and then ruling out the other possibilities. My impression is transverse myelitis or adhesive meningitis due to disseminated lupus erythematosus, even though this is an extremely rare condition. Severe myelomalacia, thrombosis of spinal arteries, and degeneration of anterior and lateral columns have been reported in this disease. Personally, I have not seen a case. Of course, periarteritis nodosa, another collagen disease, is not easily differentiated from lupus erythematosus. It can occasionally cause subarachnoid hemorrhage and less frequently, in about 2% of cases, transverse myelitis. But, since this patient had lupus erythematosus and the fact that periarteritis nodosa is much more commonly seen in the male rather than the female, I would not favor this diagnosis. As less likely possibilities, I should mention hemangiomatous lesion of the cord and the so-called "cervical hypertrophic pachymeningitis." We have a case of the latter on our service at the present time. I can see no reason for considering the possibility of a cord tumor and because of the limited time I will not go into differential diagnosis. There is nothing to support a diagnosis of a cervical disk syndrome or cord trauma. As far as demyelinizing diseases are concerned, subacute combined degeneration of the cord is unlikely, because of lack of sensory impairment from posterior column involvement, lack of atrophy, and presence of pain. Furthermore, even though not mentioned in the protocol, I cannot help but think that gastric analyses had been done during the patient's long stay in the hospital. Of course, it would be of value to know the results of these tests. The patient did not have findings of multiple sclerosis, amyotrophic lateral sclerosis, or syringomyelia; and these conditions are readily ruled out. Infectious diseases, including abscess, can be ruled out beyond much doubt. Occasionally herpes zoster, may produce myelitis and meningitis; however, there is nothing in this picture to suggest a herpetic lesion. Anterior spinal artery thrombosis will not produce the findings that our patient showed. If occluded in the cervical region it will cause sudden flaccid paralysis of all four extremities, including the bladder and rectum, with loss of pain and temperature below the lesion.

To sum it up, by excluding other lesions of the spinal cord, I would vote for lupus erythematosus as the pathological diagnosis for the central nervous system disorder. Cloudy sensorium and delirium in the final stage and superimposed infection, causing septicemia, is very common in the late stage of this illness.

Dr. J. C. Kline: No specific abnormalities were noted in the chest. In the examination of the abdomen, a staghorn calculus is seen in the right kidney with several small calcific densities overlying the left renal shadow, believed to represent renal calculi there also. Multiple rounded calcific densities are also present in the region of the urinary bladder and are believed to represent bladder calculi. The knee shows a flexion deformity with marked osteoporosis of the adjacent bones. There also is a generalized osteoporosis of the entire skeleton. The spine showed no other abnormalities. Myositis ossificans is present to a moderate degree about each shoulder joint. The myelography was not done here, nor was the radiation therapy given here.

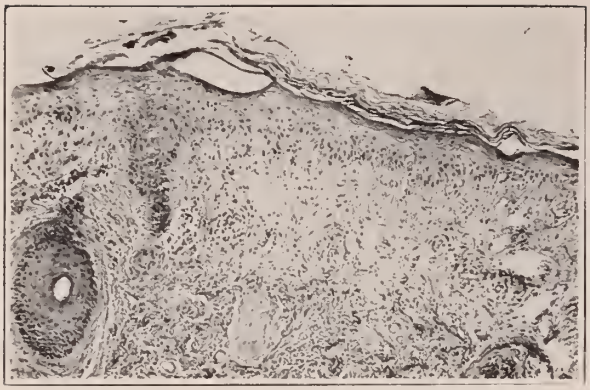

Fig. 1—Section of skin biopsy from the neck. Note hyperkeratosis, atrophy of prickle cell layer, disintegration of basal cell layer, edema and perivascular infiltrations in dermis.

Dr. W. H. Jaeschke: Sections of a tiny piece of skin from the neck revealed the following: slight thickening of cornified layer, with "basket-weave" appearance, atrophy of malpighian layer, edema in basal half of epidermis and in dermis, slight perivascular inflammatory infiltration. The impression was that of subacute to acute lupus erythematosus, with the restriction that it was difficult to be absolutely certain from the specimen (fig. 1).

Fig. 2—Both kidneys, hemisected, and urinary bladder opened. Multiple calculi located in both renal pelves and in the urinary bladder.

AUTOPSY FINDINGS

Dr. G. M. Zu Rhein: The body was that of a well-developed, fairly well-nourished white female appearing about the stated age of 55 years. Both lower extremities were fixed in marked flexion contracture. No eruptions were noted on the skin. Ecchymoses were present over the dorsum of both hands and the right upper arm. A large undermined necrotic ulcer 3 x 4 x 5 cm., exuding purulent material, was located at the right trochanteric region. Both lower extremities showed muscle atrophy and, over their lower portions, pitting edema. The essential pathological findings were encountered in the urinary tract and in the central nervous system. The left kidney weighed 115 gm., the right, 110 gm. The capsules stripped with ease revealing several pitted areas on the surface of each kidney. Cortical markings were preserved in both kidneys; the tissue was pale, and the right renal cortex markedly thinned. The pelvis of the left kidney contained 5 grayish calculi, from 4 to 15 mm. in diameter. Another 4 mm. concrement was located at the pelvic uretheral junction. The pelvis of the right kidney contained several large calculi forming together an almost complete cast of the pelvis. Pelvic mucosa was thickened bilaterally (fig. 2). Ureters were patent and normal. In the lumen of the contracted urinary bladder, 7 black, rounded, about 2 cm. stones were found. Vesical mucosa appeared focally very hemorrhagic (fig. 2), Microscopic findings of both kidneys were similar: cortical scarring and interstitial inflammatory infiltration with lymphocytes, hyalinization of glomeruli, tubular atrophy, collections of polymorphs within tubular lumina, intimal and medial thickening of most interrenal arteries, chronic inflammation of pelvic mucosa. There was conspicuous thickening of the basement membranes of many glomeruli with a tendency to "wire loop" formation (fig. 3). In addition Bowman capsules were thickened. The major lesion of the central nervous system was found in the cervical and thoracic spinal cord. The cord appeared flattened at this segment with an average antero-posterior diameter of 5 mm. No dural adhesions were noted. Gross sections revealed an obscured structural pattern

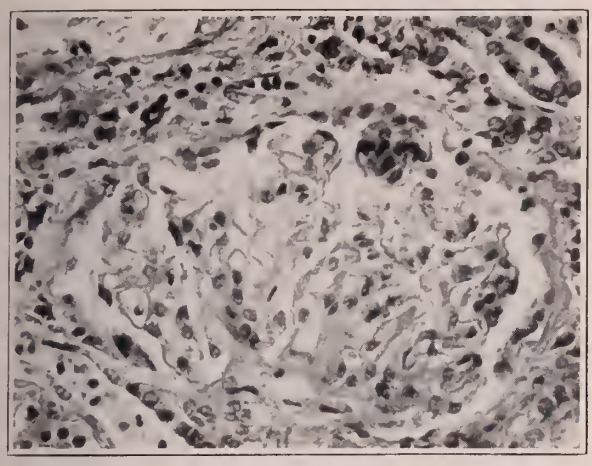

Fig. 3—Glomerulus (hematoxylin-eosin stain). Conspicuous thickening of basement membranes and "wire loop" on one margin of glomerular tuft. Bowman's capsule slightly fibrotic.

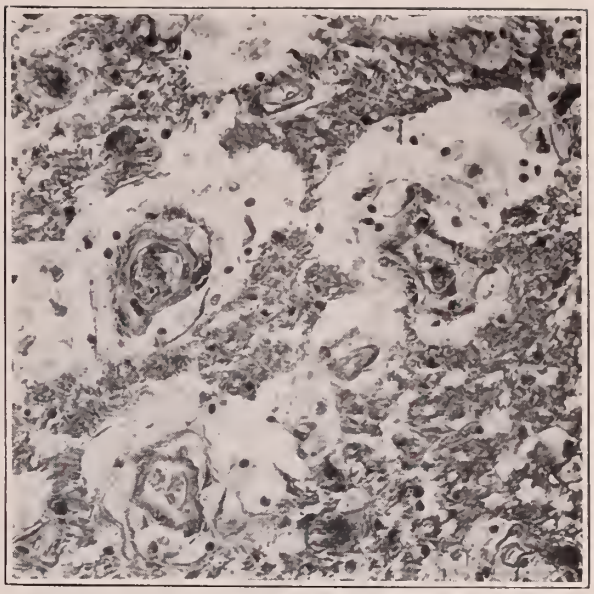

Fig. 5—Section from posterior columns in demyelinated area (hemotoxylin-eosin stain). Thickened arterioles surrounded by granular macrophages. Bridges of nervous tissue in between. Bodian stains showed most axis cylinders preserved in these tissue bridges.

and mottling of the white matter, especially of the lower cervical and upper thoracic cord. Microscopically (hematoxylin-eosin, van Gieson Bodian, Weil, Holzer stains), an extensive degenerative process was found, involving predominantly the white matter of the posterior columns, to a lesser degree the lateral columns, and least the anterior columns (fig. 4). The distribution of the degenerative areas varied at the different levels of the cord; the lesions were fairly well demarcated and did not coincide with certain tracts. At all levels the posterior columns were almost completely involved. The process was characterized by demyelinization, associated with status spongiosus, abundant adventitial and perivascular glial macrophages, and a moderate loss as well as degeneration of axis cylinders. The lack of astroglial reaction as well as the tortuosity and collagenous, sometimes hyaline thickening of small arteries

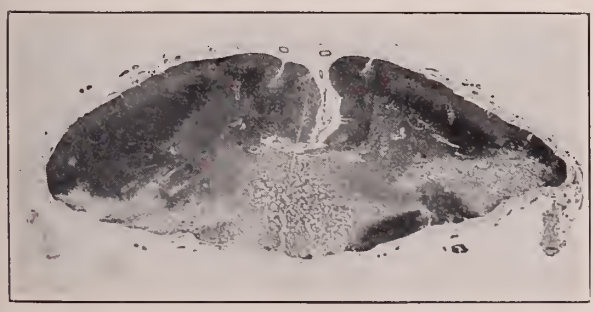

Fig. 4—Section of lower cervical cord. (Weil myelin stain). Areas of demyelinization of posterior and lateral columns. Note "status spongiosus," especially of posterior columns.

were striking findings (fig. 5). Nerve roots appeared uninvolved. The brain showed the microscopic features of prolonged hypoxia. Additional lesions were encountered in the heart and gallbladder. The heart weighed 280 gm. and showed minimal coronary sclerosis. Adiposity of the right ventricle was so marked that the trabeculae appeared diffusely yellow, and only a few myocardial fibers were seen grossly. A section of the left ventricle showed microscopically fibrinoid degeneration of interstitial connective tissue and slight interstitial myocarditis in some areas. The gallbladder was contracted, fibrotic, and contained 7 dark green stones, approximately 2 cm. in diameter.

Autopsy Diagnoses: Pyelonephritis, chronic and acute, with calculi. Cystitis, chronic, with calculi.

Subacute combined degeneration of the spinal cord.

Lipomatosis, heart.

Cholecystitis, chronic, with cholelithiasis.

Necrosis, subcutaneous, right buttock.

Question of disseminated lupus erythematosus (skin, kidneys, heart).

Dr. E. P. Roemer: The initial symptom of pain makes me doubt the diagnosis of a subacute combined degeneration.

Doctor Javid: I think this is an instructive case, especially for the medical students, to emphasize the importance of careful neurological examination. If one had adequate information regarding sensory impairment, the diagnosis, as well as correlation between clinical findings and pathological sections, presented by Doctor Zu Rhein would have been easily made.

Dr. H. H. Reese: I agree with Doctor Javid, and also wish to emphasize the importance of a thorough sensory examination. From the information we had we could not make the diagnosis of subacute combined degeneration.

Student: Why could the cutaneous and neurological manifestations not have been due to pellagra?

Dr. D. M. Angevine: From the pathologists standpoint we cannot exclude such a possibility. However, there was no history to suggest dietary deficiency and the skin lesions cleared completely without specific therapy.

Doctor Zu Rhein: The disease leading to the fatal outcome in this case was the extensive acute and chronic pyelonephritis and cystitis associated with multiple calculi. The calculi are attributed to the loss of skeletal calcium associated with immobilization. Subacute combined degeneration of the spinal cord has been reported to occur in a variety of conditions, namely pernicious anemia, diabetes, pellagra, and chronic infections, especially of the kidneys. In this case the severe renal infection seems to be the most likely predisposing disease. Involvement of the spinal cord by lupus erythematosus arteritis appears to be a very rare complication. Doctor Piper has reported a case of extensive cord lesion in lupus erythematosus in which the meningeal vessels were involved with necrotizing alterations in the walls and extensive perivascular inflammation. An infarct of the cord developed subsequent to thrombosis of the vessel. Although the skin and glomerular findings in our case are strongly suggestive of lupus erythematosus, there are so many characteristic features of this condition lacking—such as lupus erythematosus cells, hematoxylin bodies, alterations in the splenic arteries, etc.—that we cannot make a definite diagnosis of lupus erythematosus. ACTH therapy, of course, may have altered the picture as it frequently does.

(Continued from page 174)

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Noise Problems In Industry

As It Looks to the State Board of Health

THE problems inherent with industrial noise are many, and hearing loss claims are probably the main impetus which pushed them to the top of the hill. In the last few years, industrial noise has received as much published scrutiny as the present question of the effects of ionizing radiation. Ophthalmologists, otolaryngologists, acoustical engineers, and many others have been sought after to bring this problem "down the other side of the mountain."

To the uninitiated, the feeling that the noise problem has been "coasting" is readily conceivable. One revelation was that, when those concerned first gathered for advice from medical and engineering consultants to find out "which way was up," they became aware that all of the going was not uphill.

There were, of course, differences of opinion as to the noise level, nature of the noise, length of exposure, and other factors responsible for loss of hearing. Tentative standards were suggested. What became readily apparent was that there was no simple answer to noise abatement problems. There was also no single total noise pressure level that could be suggested as a reasonable goal to stay below to insure against loss of hearing.

Most authorities now agree that the frequency or pitch of the noise is worthy of as much consideration as the total noise level. In other words, the decibel level of a fairly high-frequency noise can be more damaging than the same decibel level of a low-frequency noise.

The tentative standard used by the Wisconsin State Board of Health's Industrial Hygiene Division is that proposed by Hardy.[1] Noise studies conducted by this Division consist of an octave-band frequency analysis of the noise at specific locations or operations.

Recommendations included with these studies where noise risks are found follow the consensus of medical and engineering practices, namely:

1. Whenever feasible, noise levels should be lowered by engineered control.

2. Where noise levels cannot be lowered, well-fitted ear plugs or muffs should be worn to protect the inner ear. These devices will attenuate as much as 20 decibels or more of the noise (this is a great deal, when one realizes that removing one-half of a group of equally noisy machines from a room will only decrease the noise level by about 3 decibels). Plain cotton is of little or no value in protecting the inner ear against noise.

3. Pre-employment physical examinations should include audio-metric measurements.

When carefully considered, the above three recommendations benefit the employer as well as the employee.

In 1954, the Wisconsin Council of Safety found in a survey of 127 plants that 35 per cent had undergone noise studies. Two-thirds of these studies were made by insurance companies. Where a potential noise risk was found, over 90 per cent initiated some form of noise abatement or ear protection, while three-fourths of the plants used pre-employment audiometry. Plants whose managements were aware of a problem without having utilized a noise study were relying mainly on pre-employment audiometric measurements, with less emphasis on noise abatement or ear protection.

While this survey covered only a small portion of industry, it did reveal another interesting bit of information. Every plant whose management felt it did not have a noise problem, without the benefits of a noise study to strengthen their conviction, utilized pre-employment audiometric measurements, with no form of noise abatement or ear protection.

Many problems connected with noise are still with us. If the publicity on the subject seems to have lessened, it may be only because some of the problems have lessened. Well-designed ear plugs have practically replaced ineffective cotton. Many noise abatement programs have been gratifying. The absence of pre-employment audiometric measurements in a noisy industry seems to be as rare today as the absence of a pre-employment chest x-ray in a dusty trade.—EDWARD J. OTTERSON, *Engineer, Division of Industrial Hygiene.*

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Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee
F. E. SHIDEMAN, M. D., University of Wisconsin, Madison

A New Sulfonamide

The sulfonamides are still important drugs despite the efforts of some antibiotic protagonists to efface them completely. In shigellosis, infantile diarrhea and vomiting, and cholera they are still the drugs of choice; and together with antibiotics they are essential components of the attack in the following: meningococcal infections and actinomycosis (with penicillin), brucellosis (with tetracyclines and streptomycin), plague (with streptomycin), urinary tract infections (with tetracyclines and methenamine mandelate), Hemophilus influenzae infections (with tetracyclines), and psittacosis, trachoma, etc., group (with tetracyclines). And they are the ace in the hole whenever the antibiotics are not fulfilling expectations. Sometimes they are preferred also to penicillin in the prophylaxis of rheumatic fever.

So the introduction of a new sulfonamide is a potentially important event. William P. Boger and associates[1] report on the use of a new long-acting sulfonamide, sulfamethoxypyridazine (Kynex), in 68 patients. Plasma concentration studies showed that therapeutically significant titers are achieved promptly and maintained for many hours with this drug. After a single oral dose of 1 gm., patients showed consistently demonstrable plasma concentrations for as long as 48 hours; in an occasional patient the drug was still present in the circulation at 96 hours. When a single 2 gm. oral dose was given, all except 2 patients had the drug in their circulation for as long as 96 hours and some for as long as 168 hours. After attaining the peak within the first hour or two, the plasma concentration declines steadily and more or less predictably so that roughly half of the peak level is observed at 24 hours.

From 40 to 60% of the dose was accounted for in the urine within 48 hours, and about 50% of the excreted drug was in acetylated form.

Diffusion of sulfamethoxypyridazine into the cerebrospinal fluid occurs to a greater extent than with some other commonly used sulfonamides.

The antibacterial and pharmacologic properties of the drug give every anticipation of dosage schedules that will be therapeutically effective and, at the same time, distinctive and unique among current sulfonamide drugs. It seems entirely possible, in the opinion of Boger's group, that oral doses, given about every 24 hours, will be found suitable for the treatment of acute infections, and may be given less frequently when the drug is employed for long-term prophylaxis.

It is unfortunate that the drug acetylates to such great extent in an insoluble form, since this means that some urinary tract damage is probably to be anticipated when the drug is more widely employed.—HARRY BECKMAN, M. D.

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Dr. Owen Locates in Madison

Dr. R. H. Owen, having recently completed a tour of duty with the U. S. Navy, has opened a general practice in Madison. Before entering the Navy in 1955, Doctor Owen attended the University of Wisconsin, graduated from medical school in 1953, interned at St. Mary's Hospital in Madison, took a general practice residency at the Monroe Clinic and was a staff member of the Mendota State Hospital for four months.

Doctor Returns to Hillsboro

Dr. M. J. McCarthy has re-established his practice of medicine and surgery in Hillsboro and has also reopened his office in Ontario. He had spent the past year in Washington, D. C.

. . . . THE PRESIDENT'S PAGE . . . .

"Men do less than they ought unless they do all they can."—CARLYLE

I HAVE on previous occasions stressed the importance of unity as the keystone upon which the house of medicine must be built if it is to withstand the savage onslaught of those who would make medicine the servant of the state.

In this modern era, in which all segments of human endeavor are vying with each other for survival, even unity of membership is of itself inadequate to ensure a place in our American system of free enterprise. No nation, however rich and powerful, in fact, no group of people, however well organized and influential—has been able to stand alone. All have needed allies.

American medicine recognized that fact a long time ago. Even if complete unity within our ranks were possible, we still would need friends.

Are we doing all we can to enlist allies in the cause of unshackled medicine? Are we doing all we can to strengthen the bonds between us and those who are already sympathetic to our cause? Are we doing all we can to show that we try to understand our friends and that we appreciate what they are doing for us?

Emerson in his essay, "Of Friendship," wrote, "The only way to have a friend is to be one".

American medicine throughout its more than 100 years of existence has had many friends, of course. Some have been attracted to us by reason of the principles and ethics that guide the physician in his daily conduct. Others have respected the high moral and intellectual caliber of doctors of medicine. Many have valued above all else our consistent and determined opposition to the federalization of our national economy. Many have become our friends because of a kinship born of the philosophy that after all each one of us is his brother's keeper.

I believe devoutly that the Woman's Auxiliary with its component state and county organizations was created on the basis of a creed that encompasses all of these attributes. The Auxiliary throughout its more than 35 years of existence has proven to be medicine's most vigorous and effective ally.

John W. Cline, M.D., past president of the American Medical Association, in speaking to the Woman's Auxiliary of the American Medical Association, said "You ladies represent the most potent organization allied with medicine. You understand its real aims and objectives. You appreciate the great harms which would come to the people of this country should medicine become socialized. Upon you lies a large part of the responsibility for the public relations of the profession. As individuals you possess great power to influence the opinion of the public on important health issues. We can rely upon you, and the American Medical Association is grateful for that fact."

The physicians of Wisconsin should be proud that their Auxiliary exemplifies the ideals expressed by Doctor Cline and so capably fulfills the responsibilities he outlines for them. At the same time, each of us should re-examine our relationship with the wives as Auxiliary members to be certain that they receive our fullest support and interest.

Harry E. Kasten, M.D.

"Wake in our breast the living fires,
The Holy faith that warmed our sires. . . ."
OLIVER WENDELL HOLMES, M. D.

. . . gleanings from the Section on Medical History

Back in 1918, Dr. E. J. Barrett, of Sheboygan, wrote the following sketch of Wisconsin medical history in *The Wisconsin Medical Journal:*

". . . At the junction of the Wisconsin and the Mississippi, the little city of Prairie du Chien has been in the making since 1767 —Dr. Brunson, a local historian, disputing an earlier date. It was here that Ft. Shelby, named in honor of Kentucky's first governor, was erected, and over this fort in 1815, Old Glory first floated over Wisconsin. The city was captured by the British the same year and the fort was renamed Ft. McKay. A few months later, a battalion from Jefferson Barracks, Missouri, drove the British back to Mackinac, rebuilt the fort and named it in honor of Pres. Monroe's secretary of state, William H. Crawford.

"The old fort stood on an eminence overlooking the two rivers. All that is left of it is a little government cemetery containing the graves of some of its former occupants and a mass of stone ruins. The roofless end of a building of what at one time was the hospital is fast falling to pieces, and the writer on inspecting it last fall requested the owner to fill the cracks with concrete and check its rapid decay. For a small sum, this ruin and a few acres of ground can be purchased and preserved.

(That is what the State Medical Society is doing right now, as it strives to build the Medical Museum of Wisconsin. The land was purchased and plans formulated to erect a museum, pavilion and office, and reconstruct the hospital as it stood years ago).

"At this garrison, Lt. Zachary Taylor, afterward president, was in command—when Black Hawk ruled the Indians—and the old traditions point to a tree still standing in one of the city streets that Black Hawk climbed to reconnoitre and watch the American troops. To the westward a mile away stands a low stone building built by John Jacob Astor for a fur station.

"The word *History* carries with it the idea of the doings of an ancient race and a chronicle of the lives of a people now dead, and all but forgotten, yet today, yes right now, we are living in an age where history is being made, not by pamphlets, but by volumes.

"Geography made the history of Green Bay, Portage and Prairie du Chien, but every city and county in the state has its medical past.

"Never has the profession of Wisconsin been called upon for service and sacrifice as today, service in the greatest cause that ever brought nations to war, service under the Old Flag that has never known defeat. To have been a part of this struggle, to be a part, is the medical history of the state."

Dr. Barrett, who died in 1940 at 71, practiced in Chicago before coming to Sheboygan in 1905. He was an attending physician at the Iroquois Theater fire in Chicago. He served as a colonel in World War I, being one of the few medical officers with army experience. In 1917 he made a tour around the state recruiting medical officers.

Dr. Barrett was later stationed in New York City, commanding the Fox Hills Hospital. After the war, he handled medical claims for Civil War, Spanish-American War and World War I veterans.

In the early 1920's, he was elected national vice commander of the American Legion and state commander for the same group. He was a member of the A.M.A. and an honorary member of his county and state medical societies.

the Wisconsin Medical Journal

STATE MEDICAL SOCIETY OF WISCONSIN
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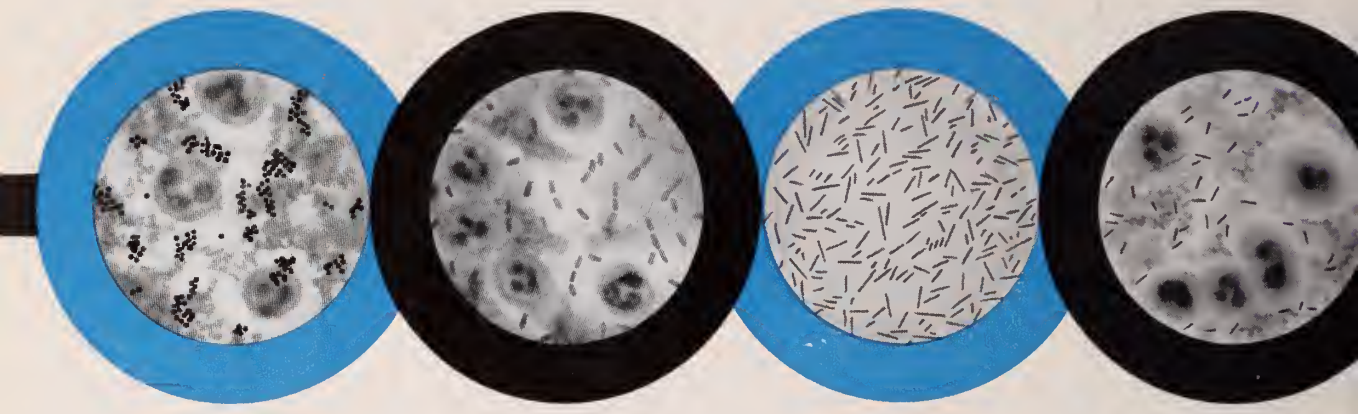

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*Adapted from Roy and others.[1]

THE WISCONSIN MEDICAL JOURNAL

Volume 57
Number 5

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3	10	15	3½	5	5	650
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6	13	22	4	7	5	768

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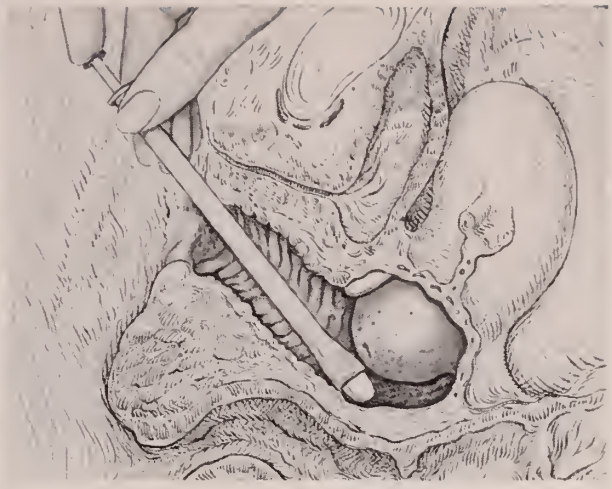

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*Williamson, P.: Trichomonad Infestation, M. Times *84*:929 (Sept.) 1956.

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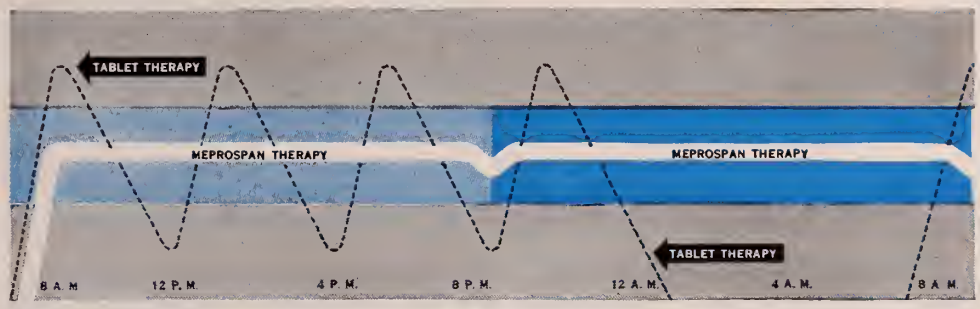

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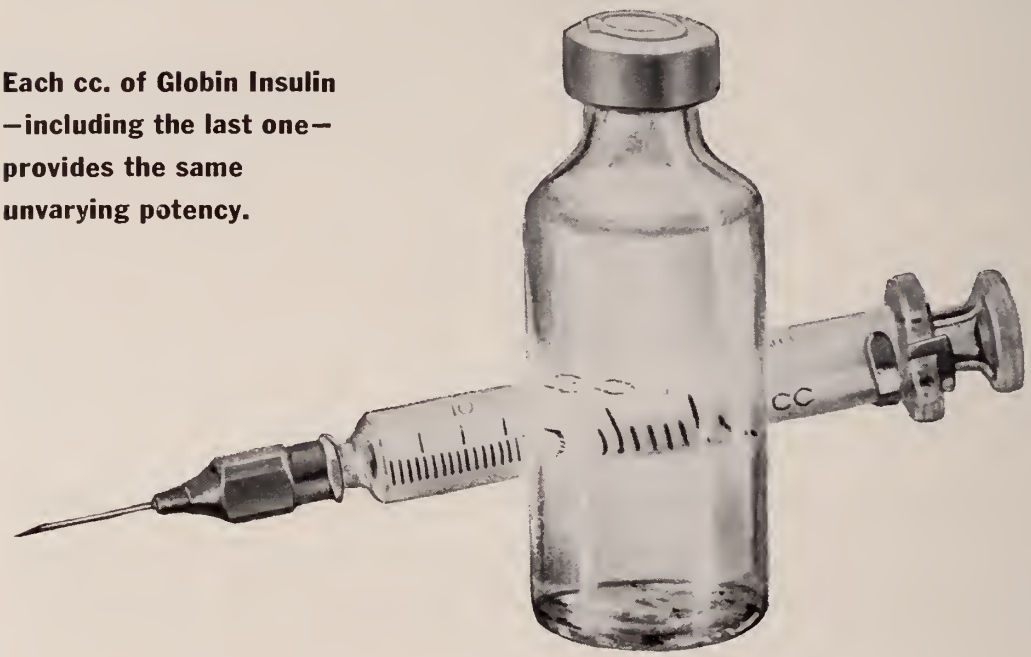

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base or the hydrochloride alone. In addition, the average levels derived from the tetracycline base or the chlortetracycline base were higher than those produced by the corresponding hydrochloride though lower than those resulting from the mixture containing the base and sodium metaphosphate. In the study with chlortetracycline[6] capsules containing a mixture of the hydrochloride and sodium metaphosphate were also included in the crossover, and the average levels produced by these capsules were the same as with the mixture of chlortetracycline base with sodium metaphosphate.

Although the enhancement of blood levels of tetracycline by phosphate, either complexed to the tetracycline or mixed with the base or the hydrochloride, thus seemed fairly well established, some doubts still remained because certain reliable observers (including many whose results have not been published) failed to confirm the findings with the materials and methods they used. Further confusion seemed to be added by a subsequent report of Welch et al.,[7] who, in repeating a crossover study with capsules of tetracycline phosphate complex and tetracycline hydrochloride with and without sodium ... phate, found ...

antibacterial activity than was observed in their absence. Oil and sorbitol did not interfere with tetracycline absorption.

Dicalcium phosphate is widely used as a filler in various capsules, including those of the tetracyclines. The authors cite a large number of other studies that implicate the presence of calcium ions as the cause of the reduced absorption of tetracyclines and show that citric acid can partially neutralize this effect. The depressing effect of food on the serum levels of tetracycline is likewise explained by the goodly amount of minerals contained in commercial laboratory diets, and they postulate that the multivalent cations may be responsible for the poorer absorption of the drug. The authors could not explain the failure of citric acid to enhance serum concentrations when administered with tetracycline base in contrast to its marked effect when given as the hydrochloride. However, they hypothesized that the ability of citric acid to enhance serum levels of tetracycline is ... to its ability to form complex... unavailable for ...

"...Tetracycline hydrochloride and citric acid, in an encapsulated mixture, produced higher serum concentrations and greater urinary excretions, and hence better absorption of tetracyclines, than any other preparation studied..."

... were published simultaneously with the last mentioned report of Welch et al.[7] These data were based on thoroughly controlled studies ... and include additional ... conclusively ...

... addendum to the last mentioned paper of ... et al.[7] indicates that in their study the capsules of tetracycline hydrochloride, chlortetracycline hydrochloride and tetracycline phosphate complex all contained dicalcium phosphate as a filler, whereas the capsules containing citric acid and sodium hexametaphosphate did not contain any dicalcium phosphate. This could clearly explain the discrepancies noted in that study. Likewise, the inconsistencies in other studies may very well have been due to the ... of calcium as fillers in sor... thers. ... however, ...

Editorial.
The New England Journal of Medicine.
258:97-99, (January 9) 1958.

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25. Weidma
73:58, 1

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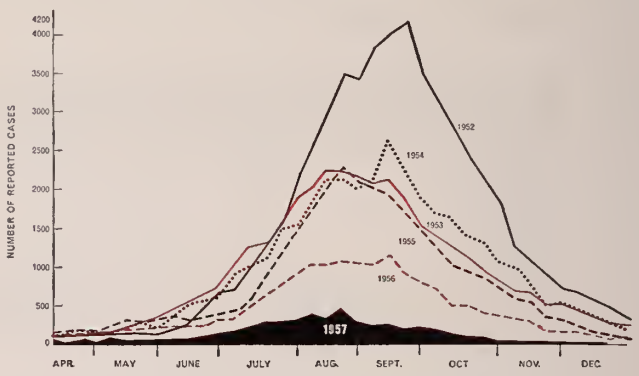

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(data compiled from U.S.P.H.S. reports)

vaccine is plentiful for the job remaining

There are still more than 45 million Americans under forty who have received no vaccine at all and many more who have taken only one or two doses.

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1. *J. A. M. A.*, 165:21 (*November 23*), *1957*.
2. *Department of Health, Education, and Welfare: News Release, October 10, 1957.*

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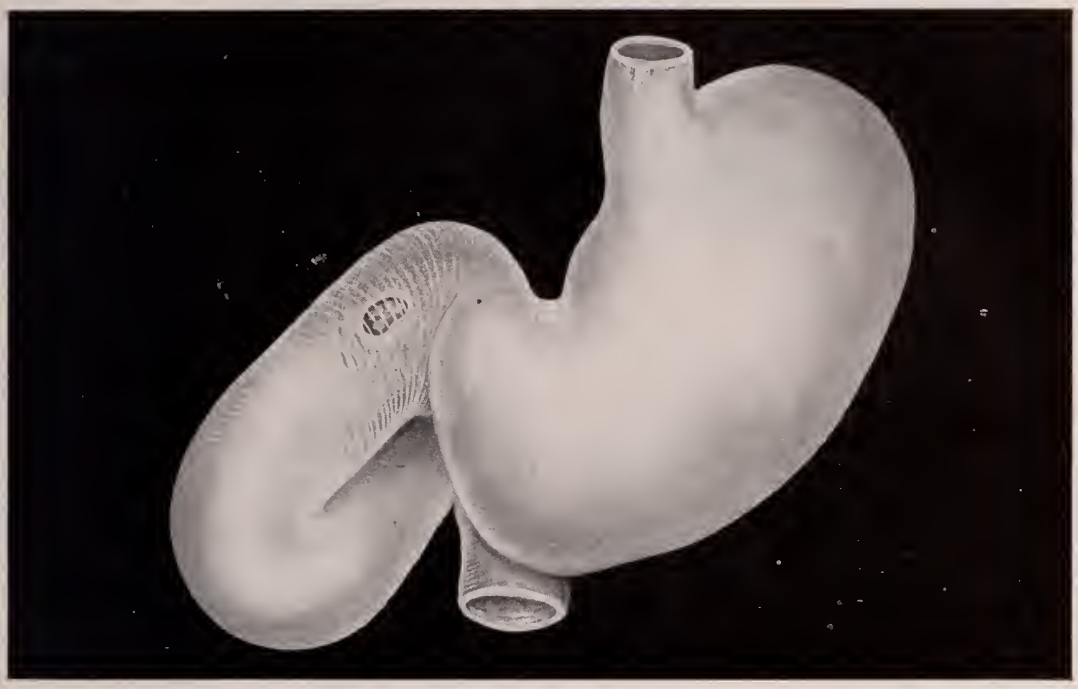

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"Our findings were documented by an intensive and personal observation of these patients over a 2-year period in private practice, and in two large hospital clinics with close supervision and satisfactory follow-up studies."*

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*Lichstein, J.: Morehouse, M. G., and Osmon, K. L.: Pro-Banthīne in the Treatment of Peptic Ulcer. A Clinical Evaluation with Gastric Secretory, Motility and Gastroscopic Studies. Report of 60 Cases, Am. J. M. Sc. *232*:156 (Aug.) 1956.

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More than seventy medical society-sponsored Blue Shield Plans are serving nearly one-fourth of the people of the United States, and underwriting about 40% of all the basic surgical insurance and about 50% of all the basic medical (non-surgical) insurance now in force. The rest is underwritten by more than 800 private insurance companies and independent local plans.

Is medicine—by its sponsorship and control of Blue Shield—in the "insurance business"? Let's remember, first, that the medical profession organized these Plans at a time when the insurance industry said it couldn't be done.

Blue Shield succeeded because America's doctors were behind it. They accepted less than normal schedules for their services; they agreed to accept (and in some areas they have actually accepted) prorated portions of those fees when the local Plan has been unable to pay the full schedule. Now that Blue Shield Plans are on their feet and financially sound, proration is a thing of the past. Yet it stands as positive assurance of physicians' devotion to an ideal in patient relationships. Medicine's leaders have accepted the responsibility for guiding and directing their local Blue Shield Plans—a job that accounts for an incalculable number of unremunerated hours on the part of hundreds of the country's busiest physicians.

Have the members of our profession accepted these duties and responsibilities in order to put medicine "in the insurance business"? Certainly not! Medicine is in the business of providing medical care—nothing else. The profession has always been concerned with the ways and means by which patients pay for medical care and provide for future medical needs.

Medicine is *not* in the insurance business. But, through Blue Shield, the profession *is* in the business of helping patients pay for their doctors' services. Physicians have a long and worthy tradition of concern for those whose health care has imposed serious economic burden. Had the private insurance carriers felt able to pioneer the economic side of medical care protection, including the low income groups, Blue Shield plans might never have started. However, the fact remains they did not feel able and perhaps are not able to pioneer this type of protection. Therefore, medicine must continue to lead the way. If this be the "insurance business" yes medicine is in it.

For Information or Advice

Write: P. O. Box 1109, MADISON, WIS. *Phone:* ALpine 6–3101, MADISON, WIS.

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Volume 57 MAY 1958 Number 5

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Psychosomatic Phraseology

Now that psychosomatic medicine holds such an elevated place in our thoughts and in medical literature, it may be of interest to recall some of the many phrases and figures of speech which express bodily symptoms generated by emotional states.

Many of them are as old as our language itself. A generation ago, Walter B. Cannon referred to them as body talk—symptoms due to fear, anger, joy, or sadness—when the body talks back to us. Almost any organ or system makes these responses when we are under some psychic strain. Another term is organ language.

The list is almost legion, and often in the past we have been tempted to dub patients' symptoms as imaginary. Now we know better. There are no imaginary sensations of illness. It is often very helpful to recall to a patient some of these figures of speech which so well describe actual symptoms.

For instance: he was *itching* to give him a piece of his mind; or *aching* to take a whack at him; he *burns* me up; he gives me the *gripes*.

Dysphagia is expressed figuratively: I can't *swallow* his insults; or she can't *swallow* her life situation; or he was *choking* with rage.

Hysterical attacks are exemplified by the following: fear striking one dumb; becoming rooted to the spot; being paralyzed with fear; or blinded with rage; his legs went out from under him; he was numb all over; he swooned at the sight.

In poetry there are countless examples of psychosomatic phraseology: "My heart aches and a drowsy numbness pains my sense." "My heart leaps up when I behold a rainbow in the sky." "Right as an aspen lefe she gan to quake." "Make my seated heart knock at my ribs gainst the use of nature."

One can find phrases for almost every functional disorder: fainting, weakness, pallor, blushing, palpitation, chest pain, dry mouth, headaches, nausea, gas, body aches, sweating, pruritus, paresthesias, dizziness, incontinence, aphonia, paralysis.

A dry tongue is expressed as "my tongue clove to the roof of my mouth." "My mouth was so dry I couldn't spit." Other common phrases are: "He broke out in a cold sweat." "Everything went black before my eyes." "His hair stood on end." "He was dizzy with fright." How often have we heard: "So and so gives me a pain in the neck; or a headache; or a pain in the rear."

It is easy for most people to understand these effects when a person is under sudden strong emotion. It is harder to undertsand, but no less true, that chronic ills and symptoms are more frequently due to long continued lesser anxieties and worries,

producing less severe symptoms over long periods of time.

Contrariwise, though we as physicians hate to admit it, the cheerful outlook of a Christian Scientist may help regulate and smooth bodily functions and prevent a lot of organ langauge. "A happy heart makes a blooming visage." Again in discussing symptoms of functional disorders with patients, recalling these figures of speech often helps convince them of the true nature of their trouble, and helps lay the foundation for beneficial therapy. This approach is more intelligible than discussing neuroses and the autonomic nervous system and its relation to emotional states.

One of the oldest aphorisms in medicine is that the three best physicians are Doctors Quiet, Diet, and Merryman.—H. P. Greeley, M. D.

Blue Shield—America's Unique Contribution

In these days of instantaneous communication and overnight travel to the most remote places in the world, few nations can claim any social ideas or innovations as exclusively their own.

But the fact is that in the field of medical economics, American medicine has produced a program that is uniquely American. There is nothing comparable to Blue Shield in any other nation today.

Specifically, in no other country has the medical profession been able to develop a nonprofit plan for medical care prepayment in which the participation of both patient and doctor is voluntary; there is complete freedom of choice for doctor and patient; services are paid for on a fee-for-service basis with the payments subject to medical control; there's no third party to regulate the doctor's practice; and no governmental agency has contributed one cent of direct subsidy to the program.

As a spokesman for the World Medical Association, the "international voice of organized medicine" representing 750,000 physicians in 53 nations of the "free world," said recently: "American physicians are singularly fortunate in having met their social and economic problems by voluntary action, turning back the threat of political domination."

Of course the plain fact is that although physicians have *met* their social and economic problems, they are still a long way from *solving* them. Through their own Blue Shield program and with the help of the many commercial insurance companies that have followed the trails blazed by Blue Shield, physicians have made a strong and substantial beginning toward providing basic medical care security for all of their patients.

But there are big and difficult problems yet to be solved—in the care of long term and chronic illness, the aged, the rural populations, the indigent, etc.

Blue Shield offers us a unique instrument with which to tackle these problems. Whether or not it will yet suffice to save America from resorting to the state socialism and the compulsory solutions that most other countries have adopted will probably depend on the vision and energy and public spirit which every doctor brings to the support and guidance of his own Blue Shield Plan.

Rural Life Still Healthier

Surprising as it may seem to Wisconsinites, city dwellers have only recently, and then just barely, caught up with the rural citizen in that important matter of good health. At least that is the conclusion of a recent report of the Health Information Foundation based on an analysis of the nation's vital statistics.

For example, the typical New Yorker in 1901 could expect to live seven years less than the average American. Today New Yorkers have practically the same life expectancy as anyone else.

Big cities in the past have had a deservedly bad reputation for disease and death. Plagues and epidemics took a heavier toll of city dwellers, and infectious diseases flourished in cities even in normal times.

The rapid gain in urban health levels is due largely to organized public health achievement and to the greater availability of physicians, hospitals and other diagnostic and treatment resources.

Although advances in transportation have made these resources more accessible to those who live in rural areas, rural populations have not yet developed habits of consulting physicians and using resources to the same degree as city dwellers. There are many reasons why this is true, not the least of which are cost and inconvenience. Undoubtedly these two factors will always be strong elements in the successful health care of scattered populations, but other considerations of rural living may yet keep the balance of good health in favor of rural America.

The total educational effort of the medical profession, voluntary health organizations, governmental health agencies, 4 H clubs, civic associations and farm groups themselves is nothing short of tremendous. The rural resident's willingness in the past 10 years to promote and pay for city-quality health facilities has wrought amazing change on the community scene.

Voluntary health insurance has one of its last major markets among the rural and self-employed, and many are sensing the need to buy.

In Wisconsin, at least, one of the greatest challenges to continued good health lies in junking an antiquated system of local health officials in favor of modern, effective, full time, county or multiple county health departments. Recently, there has been a beginning of interest in this direction.

These are good signs for the future of a state which is still largely rural in character. Real progress depends upon combined city-rural cooperation and some clear and forward thinking by all concerned.

Council for Health Care of the Aged

The foundation has been laid by some of the most important organizations in the health field to solve the problem of the health care of the aged. This announcement could not have come at a more opportune time.

With care of the aged fast becoming a national issue, and with government agencies moving rapidly to fill an alleged vacuum without knowing whether a vacuum really exists, the announcement of the establishment of a Joint Council to Improve the Health Care of the Aged is indeed welcome.

The Council has been established jointly by the American Dental Association, the American Hospital Association, the American Medical Association and the American Nursing Home Association.

Objectives of the Council are to identify and analyze the health needs of the aged, to appraise available health resources for the aged, and to develop programs to foster the best possible health care for the aged regardless of their economic status.

The Joint Council to Improve the Health Care of the Aged is made up of three representatives of each sponsoring organization.

One of the first jobs of the Council will be to determine exactly what are the health problems of the aged. Studies have been underway for the past several years by the organizations making up the Council; but now, through joint efforts, research will be intensified and projects for meeting the problem will be activated as rapidly as possible. The Council will be the agency through which the efforts of the sponsoring member organizations will be coordinated to solve the health problems of the aged.

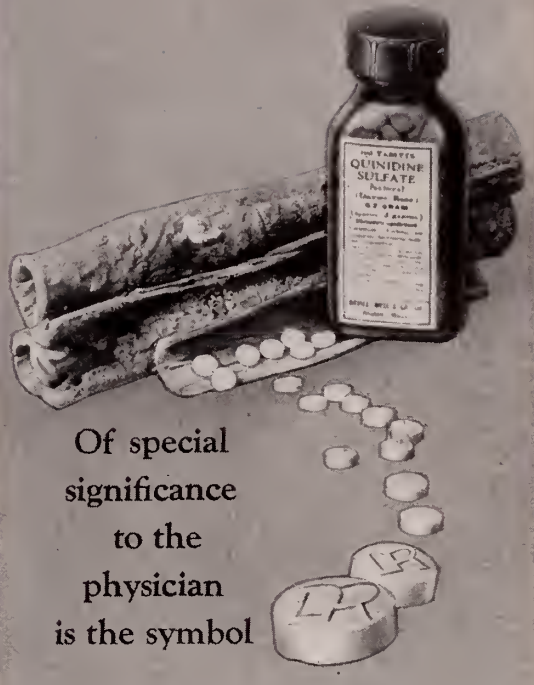
The sponsoring organizations pointed out that the need for new programs in this field is accented by the fact that the life expectancy of individuals has been constantly increasing in recent years. In 1935 life expectancy in the United States was an average 60.2 years. The most recent figure indicates the average life expectancy now to be 70.0 years.

The Council will have as one of its principal immediate projects the development of programs and facilities to be tailored to the health needs and finances of the aged.

Another facet of the Council's broad-range program will be to work closely with health insurance groups in an effort to improve the coverage of the aged and to see that their insurance dollars go further.

It is the belief of the Joint Council to Improve the Health Care of the Aged that much can be done for older people by the states and communities, and the Council will endeavor to stimulate the activities at these levels of government.

Special research projects are contemplated by each of the organizations supporting the Council. This research will then be pooled and programs developed to meet the health needs of the aged. The ultimate goal is to provide adequate health care at reasonable costs.



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Correspondence

Dr. H. E. Kasten
419 Pleasant Street
Beloit, Wisconsin

Dear Doctor Kasten:

At the recent annual meeting of the Joint Committee on Health Problems in Education which is a Committee sponsored by the National Education Association and the American Medical Association, our attention was called to the efforts of the Wisconsin Medical Society for the effort which the Society has made recently to establish policies relative to inter-scholastic athletics for youth. The Joint Committee read with great care some of your material and found it very much in the pattern which the Committee has established in recent years and hence it is our desire to congratulate the Society on your stand and on your recent efforts in this connection.

Surely the problem is a most difficult one and to affect the thinking of educators throughout the nation, we will have to set forth both the medical and the educational viewpoints on this problem with considerable clarity and reason.

The Joint Committee believes that such efforts as your Society has expended are quite in the direction which we would hope others will take.

Yours very truly,
/s/ Del Oberteuffer
Professor and Chairman of the Joint Committee on Health Problems in Education 1957–58

1958 SUMMER CAMP PROGRAM FOR DIABETIC CHILDREN

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GIRLS' CAMPING SESSION: August 3–16, Ages 9–15, Camp Sidney Cohen on Lake Nemahbin.

The Association provides special facilities including a professional registered nurse, dietitian, and daily visits by a physician member to check insulin requirements. Insulin is provided by the WDA without charge to campers. Facilities are also available at camps in other areas of the state.

For further information write: Mrs. Donald Turek, Camp Chairman, Milwaukee Lay Society of the Wisconsin Diabetes Association, 756 N. Milwaukee St., Milwaukee 2, Wisconsin.

Postgraduate Course on the Evaluation of Pulmonary Function

The Wisconsin Society of Internal Medicine will present a four-hour course on the evaluation of pulmonary function on Sunday, June 8, in Madison. This is the day following the Wisconsin Heart Association meeting in the same city. All interested physicians are welcome and are urged to attend. There will be no charge for registration.

The use of simple apparatus, practical for the private practitioner's office, will be demonstrated; and the indications for and significance of more complex tests will be discussed. The application of these data in clinical diagnosis, disability evaluation, and industrial compensation work will be explained.

Typical cases will be demonstrated.

Tentatively scheduled to participate are the following doctors: John Rankin, Helen Dickie, Quinton Callies, and Richard Johnstone of Madison, and Ross Kory and O. A. Sander of Milwaukee.

The session will begin at 10:00 a.m. and will conclude by mid-afternoon. The University of Wisconsin Hospitals has graciously made its facilities available for this course.

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Society Proceedings*

Brown

Members of the Brown County Medical Society heard *Dr. David Barrow* speak on "Treatment of Varicose Veins and Stasis Ulceration" at their dinner meeting held March 13 at the Elks Club, Green Bay. Doctor Barrow is an assistant professor of surgery at Marquette University School of Medicine.

Fond du Lac

Twenty-eight members of the Fond du Lac County Medical Society met February 27 at the Elks Club in Fond du Lac.

Mr. O. W. Gaarder, Madison, addressed the society on the rising costs of medical practice. During the business meeting *Dr. D. J. Twohig, Jr.* reported on a meeting with the county welfare department and city relief department concerning a fee schedule. Also heard was a report on the forthcoming city–county health council meeting. The adoption of uniform insurance forms was discussed.

Kenosha

The Kenosha County Medical Society met April 3 at the Elks Club in Kenosha. An American Cancer Society film on "Time and Two Women" was introduced by *Dr. A. L. Mayfield.* The movie was previewed for possible future release to civic and social organizations.

Manitowoc

The members of the Manitowoc County Medical Society honored *Dr. W. E. Donohue* on his retirement and gave him a remembrance for his many years of service when they met February 27 at the Supper Club, Manitowoc.

Mr. Francis Kadow of Radio Station WOMT, Manitowoc, was presented with an A.M.A. plaque for cooperation in medical education broadcasts. During the business session *Drs. W. E. Acheson* of Valders and *N. A. Bonner,* Manitowoc, were named as delegate and alternate, respectively.

Outagamie

The regular monthly meeting of the Outagamie County Medical Society was held February 20 at the Elks Club in Appleton. Mr. Robert Murphy, attorney for the State Medical Society, Madison, was the guest speaker. His talk on social security with reference to the inclusion of self-employed medical men not now covered by the program was followed by a lively discussion.

At the Society's March 20 meeting at the Golden Age Home in New London Dr. Leonard Ganser, superintendent of the Wisconsin Diagnostic Center, spoke on "Geriatrics and Associated Problems of Readjustment". *Dr. J. B. Mac Laren,* Appleton, discussed the history, growth and purpose of the Golden Age Home. At the business portion of the meeting, a motion was made for cooperation in the establishment of a county school vision program.

Polk

The Polk County Medical Society and Auxiliary were guests of *Dr.* and Mrs. *Loren Campbell* on March 20 at the Dalles House in St. Croix Falls. A St. Paul, Minnesota, obstetrician and gynecologist, Dr. N. J. Lilleberg, spoke on "Conservation of Ovarian Tissue." Also on the program was Dr. Edward Richardson, St. Paul urologist, who discussed disorders of the female urethra.

Racine

A special business meeting of the Racine County Medical Society was held March 6 at St. Luke's

* Physicians whose names are printed in italics are members of the Society.

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Nellie Voight Auditorium to discuss the recent meeting held with the county board in regard to a welfare fee schedule.

Members of the society met March 27 at the Racine County Club to hear Dr. K. Randolph Manning, Indianapolis, discuss "Utilization of the Rehabilitation Services in the Community by the Physician." Doctor Manning is an orthopedic surgeon who serves on the staff of Indiana University's Medical Center and is chairman of the Conference on Rehabilitation Centers, Inc.

The group also toured the Curative Workshop at the club.

Sauk

The Sauk County Medical Society held a dinner meeting April 8 at the Warren Hotel in Baraboo. Speaker for the evening was *Dr. Henry Okagaki* of Madison who talked on orthopedics.

Shawano

On March 19 the Shawano County Medical Society met at a local hotel for its regular dinner meeting. *Dr. D. S. Arvold* led the discussion on a medical case.

Trempealeau–Jackson–Buffalo

Phases of dermatology was the subject of a talk presented by *Dr. G. D. McAfee*, dermatologist from Eau Claire, to the members of the Trempealeau–Jackson–Buffalo County Medical Society. The meeting was held on March 25.

Walworth

The Walworth County Medical Society met at the Arizona Inn in Delavan on March 13. "Diabetes in Children" was the topic presented by *Dr. Edward Zupanc*, a pediatrician from Monroe.

Washington–Ozaukee

Smith Brothers in Port Washington was the site of the March 27 meeting of the Washington–Ozaukee County Medical Society. A panel discussion "Similarities and Differences in Medical and Legal Ethics" was led by E. J. Holman, secretary of the American Medical Association's Judicial Council. Several attorneys from both counties attended. Special guests were Philip Habermann, secretary of the Wisconsin Bar Association, Madison, and *Dr. T. W. Tormey*, secretary of the Wisconsin State Board of Medical Examiners. During the business meeting *Dr. John Walsh* was nominated as chairman of the Washington–Ozaukee county committee on public policy.

Winnebago

On March 6 the Winnebago County Medical Society held a dinner meeting at Valley Inn, Neenah. "Why Talk about the Sales Tax?" was the theme of a talk given by Mr. John P. Reynolds, Madison, vice president of the Wisconsin Taxpayers Alliance.

(Continued on page 36)

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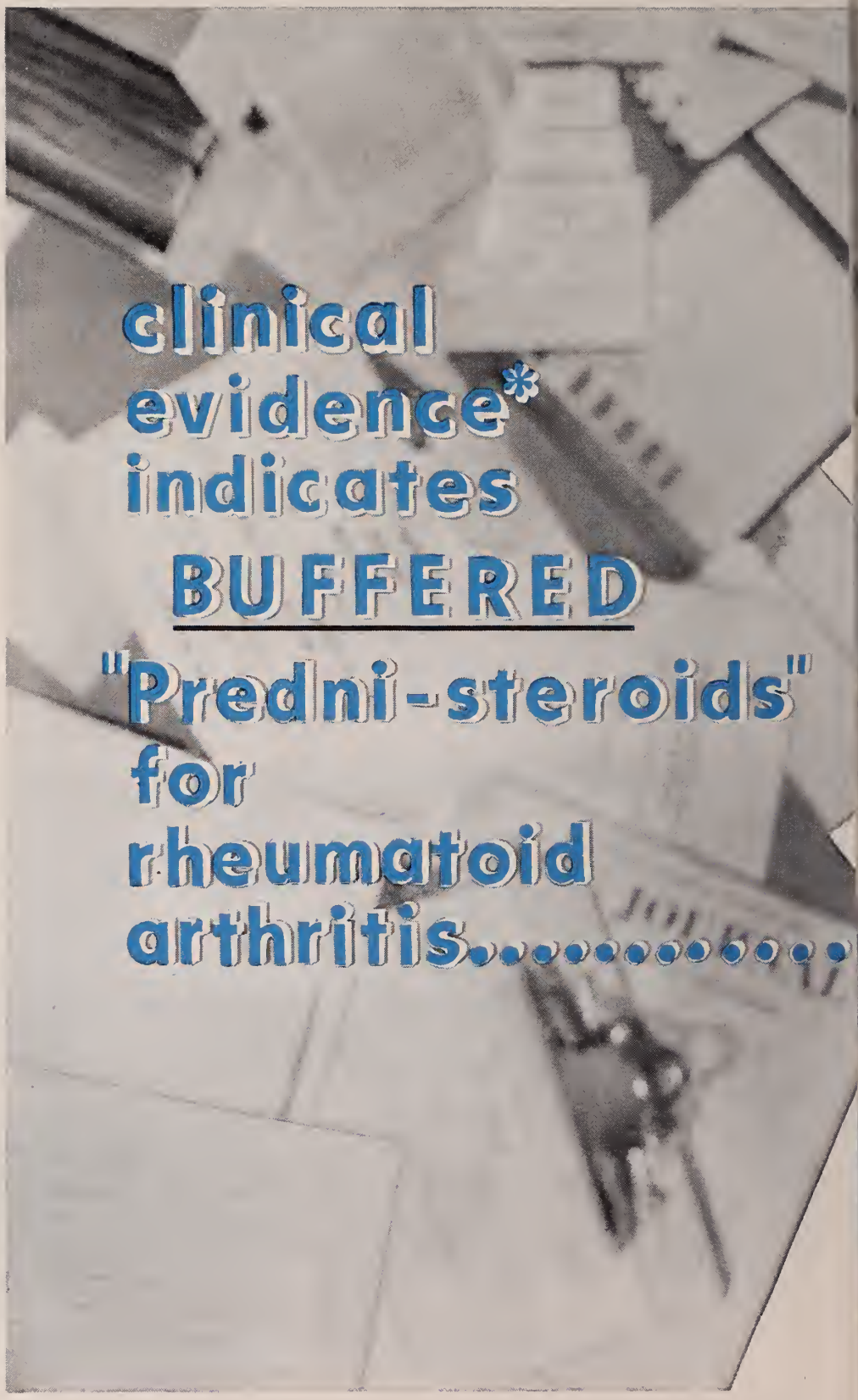
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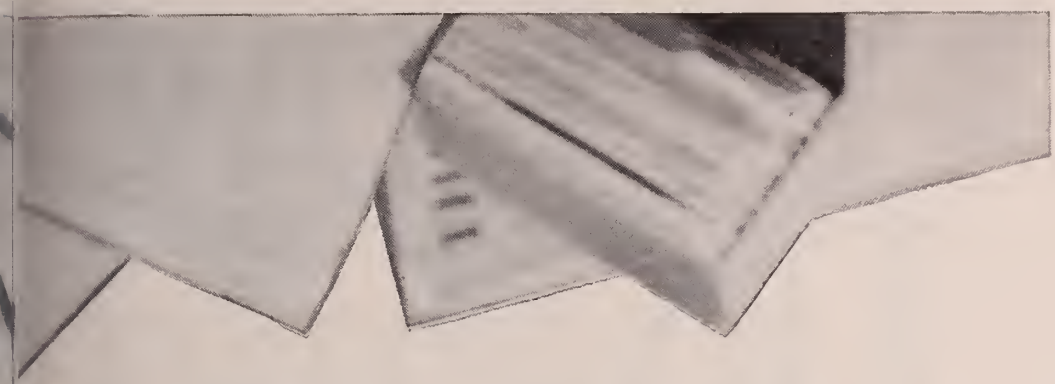

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to offset any gastrointestinal
effects."—Dordick, J. R. *et al.*:
. State J. Med. 57:2049 (June
1957.

*"It is our growing conviction that all patients receiving oral steroids should take each dose after food or with adequate buffering with aluminum or magnesium hydroxide preparations."—Sigler, J. W. and Ensign, D. C.: J. Kentucky State M. A. 54:771 (Sept.) 1956.

*"The apparent high incidence of this serious [gastric] side effect in patients receiving prednisone or prednisolone suggests the advisability of routine co-administration of an aluminum hydroxide gel."—Bollet, A. J. and Bunim, J. J.: J. A. M. A. 158:459 (June 11) 1955.

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References: 1. Grieble, H. C. and Jackson, G. G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958. 2. Editorial *New England J. Med.* 258:48-49, 1958. 3. Jones, W. F., Jr. and Finland, M., Sulfamethoxypyridazine and Sulfachloropyridazine. *Ann. New York Acad. Sc.* 60:473-483, 1957.

*Reg. U. S. Pat. Off.

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(Continued from page 31)

Milwaukee Academy of Medicine

The Milwaukee Academy of Medicine met on March 18 for a dinner and scientific program. Guest speaker was Dr. Albert B. Sabin, professor of research pediatrics at the University of Cincinnati College of Medicine. He chose "Studies on Echo 9 Virus Disease in Milwaukee" as the subject of his address.

Milwaukee Neuro-Psychiatric Society

The University Club of Milwaukee was the meeting place of the Milwaukee Neuro-Psychiatric Society on March 19. Following a dinner the members heard Dr. Gordon R. Forrer speak on "Experiences with Atropine Toxicity Therapy for Psychiatric Disorders." Doctor Forrer is the clinical director of Northville State Hospital, Northville, Michigan.

HISTORICAL NOTE

The Greek myth reports that Aesculapius was the son of Coronis, a maiden of Thessaly, and Apollo, the sun god. The young demi-god attended a school taught by Chiron who numbered among his pupils such greats as Jason, Hercules and Achilles.

Chiron was known as a master in the healing arts for which Aesculapius showed a special gift and eventually came to excel his master. Legends sprang up about Aesculapius' magic powers. He is credited with evolving dietetic cures, with establishing surgery and pharmacology, and developing such treatments as purges and the extraction of teeth.

A mythological daughter of Aesculapius, Panacea, personified the all-healing herbs. Hygeia, her sister, was devoted to preserving health and thus was one of the first embodiments of preventive medicine.

A son, Telesphorus, was taken as the symbol of the vitality of youth. In mythology he is frequently associated with "Recovery."

FILMS AVAILABLE

A revised list of films available through the A.M.A. motion picture library has been prepared and copies are available upon request from Motion Pictures and Medical Television of the American Medical Association. This catalog lists 87 medical films suitable for showing to medical societies, hospital staff meetings and other scientific groups. This catalog also includes 57 health films of interest to physicians who may be called upon to speak before lay audiences such as service organizations, Parent–Teachers' Associations, etc.

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THE MEDICAL FORUM

CIVIL DEFENSE SEEKS COUNTY MEDICAL DIRECTORS

HIGHEST HONOR—The State Medical Society's highest honor, the Council Award, was presented May 1 to Pres. Edwin B. Fred, who is retiring as head of the University of Wisconsin July 1.

Dr. R. G. Arveson of Frederic (left), assisted by Dr. William D. Stovall, Madison, (center), made the presentation at a dinner meeting in Madison attended by officers of the society, the Dane County Medical Society, the Wisconsin Board of Regents, and the university.

The Council Award cited Pres. Fred "for attainment in the fields of science, education and administration; for a distinguished career in public service; for steadfast adherence to untrammeled truth and understanding and insight into the difficult problems in medical education in a period of rapidly growing medical sciences."

A member of the Wisconsin faculty for 44 years, Pres. Fred became the school's 12th president in 1945. He will be succeeded by C. A. Elvehjem, dean of the graduate school.

Dr. Arveson, who won the Council Award in 1957, is chairman of the Council and like Dr. Stovall, a past president of the State Medical Society. Dr. Stovall was the recipient of the Award in 1940.

Established in 1929, the Award is granted rarely, and then usually to members of the State Medical Society for meritorious, distinguished service. Only twice has it been awarded to other than physicians, to the late Edward A. Birge, Ph.D., and Walter J. Meek, Ph.D., Wisconsin faculty members.

—Rolf Lunde Photo

Psychiatric Group Names New Officers

MADISON—Dr. Max M. Smith, Madison, was elected president of the Wisconsin Psychiatric Association this spring.

Dr. Leonard J. Ganser, Madison, was named president-elect; Dr. Gilbert B. Tybring, Madison, secretary and Dr. Harold N. Lubing, Madison, treasurer.

AMEF Reports Contributions

CHICAGO — Contributions from Drs. R. H. Brodhead, Wausau, and Maurice Hardgrove, Milwaukee, were reported recently by the American Medical Education Foundation.

A contribution also was received from the A. Gundersen Medical Foundation at La Crosse.

32 Named to Date, But More Needed

MADISON — Wisconsin's 32 county medical directors have taken on definite responsibilities in the over-all state Civil Defense survival plan.

Here are their duties, mainly concerned with medical care in event of an emergency:

1. Develop the county emergency health-medical services plan.
2. Appoint captains for the mobile medical teams, with assistance from the county society.
3. In reception and support areas, recruit and train sufficient personnel to operate emergency 200-bed hospital units stored in each area.
4. In target areas, coordinate planning for the evacuation of hospitals and nursing homes to relocation sites.
5. In counties of 20,00 population or more, assist the state co-director of civil defense in organizing emergency blood collecting centers.
6. In time of warning alert, and during the post-attack and post-disaster period, certain specified duties to place the survival plan into quick efficient operation.

The local county medical society is asked to participate initially in emergency planning by naming a county medical director, upon request of the county civil defense coordinator.

ANNEX PROVIDED

To cope with enemy attack or large scale natural disasters, a medical, health and radiological annex has been included in the state survival plan. Suggested principles for developing emergency medical and health services so that local medical resources can be marshalled to provide the best possible care have been drafted.

So that every county will have necessary care, the state co-direc-

(Continued on page 44)

PHYSICIANS ASSIST IN DISABILITY DETERMINATION

State Rehabilitation Division Serves As Clearance Center

MADISON—Recent amendments to the Social Security Act provided wage credit freezes to persons considered disabled, with monthly payments to those disabled over 50 and to dependent children disabled before 18.

Physicians have been requested by patients to supply medical evidence with regard to disability, and are also asked by the state to perform consultative examinations in cases of questionable disability.

Applications for benefits under this law increased greatly last year.

In Wisconsin, determinations of disability are channeled through the Rehabilitation division of the State Board of Vocational and Adult Education. Each case is adjudicated by a team of two members, one a physician, the other a division staff member. There are at present four physicians serving on these teams on a part-time basis.

Each applicant is asked to supply with the initial application medical reports from his physician or physicians. Whenever possible, a determination is made on the basis of this original information. The law requires that specific medical evidence support each claim of disability. Insofar as possible, objective evidence, such as physical findings or laboratory findings, is required.

In some cases, additional requests for specific information are sent to the patient's own physician. This information is requested at the expense of the applicant.

In some cases the division purchases a consultative examination. This may be done under the following circumstances when dealing with an original claim:

1. Available evidence suggests the presence of a disability but there is not enough objective evidence available to complete the adjudication. In these cases, a consultative examination is done to provide additional objective medical evidence to confirm the diagnosis or to establish the severity of the applicant's condition.
2. In the occasional case, verification of the medical evidence is necessary. This can only be accomplished through a consultative examination. This is often done where the available medical information is conflicting or ambiguous.

These examinations are usually purchased from specialists in the medical fields directly concerned. Some of these examinations have been done by generalists and, in some cases, by the applicant's own physician. In general, it is felt that a physician not previously connected with the patient can furnish the most objective evaluation.

Payment for these examinations is based on a fixed scale—the Wisconsin Veterans' Medical Service Agency schedule of fees. Selection of physicians to do these examinations is arranged through the District Office of the division. In general, efforts are made to utilize as many different physicians as is practicable.

After adjudication, the complete case record is sent to the Bureau of Old Age and Survivors Insurance, Baltimore, Md., where each case is again reviewed by an adjudicating team. If approved by the reviewing team in Baltimore, the decision of allowance or disallowance of the claim is forwarded to the applicant. This notification includes an explanation of the board's determination relative to the claimant's ability to perform gainful work. If the central office in Baltimore disagrees with the determination, it may be returned for further study, often with a request for a consultative examination.

Applicants whose claims are denied may apply for reconsideration. They may submit additional medical evidence if they wish. Those applicants who wish may apply for public hearings of their claims. Cases which are reopened for reconsideration or hearings frequently require consultative examinations.

(Continued on bottom, next page)

Aging Conference Set For June 4-5

MADISON—Wisconsin physicians are urged to attend the Second Wisconsin Governor's Conference on Aging, to be held here June 4–5.

The conference theme is "Wisconsin Plans for its Older Citizens," and workshops and addresses are being arranged accordingly.

Doctors in the state took an active role in the 1957 session, and those in attendance described it as a productive meeting.

The State Medical Society, one of the sponsors, will hold an institute June 6 for physicians serving in nursing homes, and for owners, administrators and supervisors of such homes. This will be held in Madison, and will center around mutual problems.

Areas to be considered at the conference this year include economic problems; health and medical care; the older person and the community; housing, professional services, and the church and the older person.

The Wisconsin Public Health Council Inc., is another sponsor of the conference.

Announce Diabetic Camp Program

MILWAUKEE—For the eighth consecutive year, the Wisconsin Diabetes Association and its Milwaukee Lay Society will sponsor summer camp programs for diabetic boys and girls.

Boys between eight and 16 will attend Camp Whitcomb on Lake Keesus from July 21 to Aug. 2, while girls, 9–15, will go to Camp Sidney Cohen on Lake Nemahbin Aug. 3–16.

The program provides special facilities to provide wholesome fun. A registered nurse is in attendance at all times, and daily visits to the camps are made by physicians who check on insulin requirements.

Information on the camps may be obtained by writing Mrs. Donald Turek, 756 N. Milwaukee St., Milwaukee 2.

ONCE AGAIN: PHYSICIANS AGAINST POLIO

MADISON—It may be Americans have to be shocked into an awareness to get their polio shots right away—before the polio season is upon us.

Over 40,000,000 children, teenagers and adults still have not been protected against polio. For these people, time is running out. The risk of disablement and even death, as every physician knows, is as great as ever for those who have not been vaccinated against this dread disease.

The State Medical Society of Wisconsin, hopeful of reducing substantially the estimated 1,000,000 persons in the state who have not yet obtained their polio shots, urges its members to conduct local campaigns in their practices. The inoculation message should be told again and again until everyone under 40 obtains maximum protection.

One or two shots do not provide adequate protection. All three are needed. Many folks are forgetting about the all-important third shot of Salk vaccine. Interest must be maintained and the urgency stressed via physician-patient communication.

Articles have been sent to newspapers, spot announcements to radio and TV stations and advertising copy to employee publications. Physicians can help to assure wider use of this material, by personal contacts. A call on an editor or station manager does much to insure publication.

Last year's experience demonstrated that public response is enthusiastic, community interest high and vaccination programs successful when medical leadership is strong.

On The S. M. S. Calendar

JUNE

3—Testimonial Dinner, Dr. W. D. Stovall
4—Claims Committee
7–8—Wisconsin State Medical Assistants Society annual meeting. Elkhart Lake
14–15—Commission on Medical Care Plans
23–28—A.M.A. meeting, San Francisco
23–27—Midwest Institute on Alcohol Studies, Madison

JULY

2—Claims Committee
25–27—Council, Land O'Lakes

Mt. Mary Proud of MD Graduates

MILWAUKEE—"We are justly proud of two of our graduates who went into medicine," an official of Mount Mary College, Milwaukee, told the State Medical Society recently.

Dr. Adeline B. Gauger, Milwaukee, is assistant chief of the physical medicine and rehabilitation service of the V.A. Hospital at Wood. For one year she served as director of the Milwaukee Cerebral Palsy Clinic.

Dr. Teresa McNeel Hascka, also a native Milwaukeean and graduate of the Marquette University School of Medicine, entered private practice five years ago in Pacific Palisades, Calif.

DISABILITY . . .

The following table gives an indication of some of the operational experiences of the State Rehabilitation Division during 1957:

TABLE I

Year 1957	*Number of Cases*	*Percentage of Total Initial Determinations*
Total Initial Determinations	5726	100
Applications acted upon as received	3674	64
Applications acted on after securing additional information through patient or his physician	1565	27
Examinations purchased by Wisconsin State Rehabilitation Division	487	9

TABLE II

Year 1957	*Number of Cases*	*Percentage of Total Initial Determinations*
Applicants found under disability	3316	56
Applicants found not under disability	2410	41
No determinations made	184	3

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MILWAUKEE WISCONSIN

Doctor, Do You Know WMA? WHO?

MADISON—Not all physicians are sure they understand the differences between the World Medical Association (WMA) and the World Health Organization (WHO).

WMA is an organization of national medical associations, including the AMA. It is completely non-governmental. It is not part of the UN, and is a voluntary organization. WMA represents the practicing medical profession.

WHO is an intergovernmental health agency. Its members are the governments that accept the principles upon which WHO is founded. This organization was founded in 1945 as the result of a UN proposal to create a specialized agency to deal with all matters relating to health on a worldwide scale.

WMA was organized 11 years ago by AMA and western European medical leaders. Its purpose was to exchange medical knowledge, to protect the freedom of medicine, and to promote world peace.

IN MINNEAPOLIS

Each member association of WMA sends two delegates, two alternates and observers to the General Assemblies, the supreme policy-making body of the association Its executive body is the council, which meets twice a year and comprises 11 members selected from the General Assembly and the president, president-elect and the treasurer.

Each member government of WHO sends three delegates, chosen preferably from the national health administration of the government to the annual World Health Assembly. The 1958 session will be held in Minneapolis, May 26–June 14. The executive board of WHO is the executive body and consists of 18 members elected to represent 18 member governments.

WMA is supported by members' dues and contributions and the annual budget is about $165,000. WHO is supported by dues allocated by a UN scale. Its 1958 budget is $13,000,000.

American physicians and allied corporations interested in the work of WMA are organized as the United States Committee of the WMA. American citizens interested in the efforts of WHO are organized as the Citizens' Committee for the WHO.

The AMA House of Delegates last June strongly urged every member to join the U. S. Committee of WMA.

WISCONSIN PHYSICIANS INVITED TO JOIN WORLD MEDICAL ASSOCIATION

MADISON—What would membership in the World Medical Association mean to you, Doctor?

It would mean:

. . . The satisfaction of sharing the advantages of American medical progress with other lands, and at the same time helping to protect the freedom of medicine.

. . . A share in representing the interests of the practicing physician before other international groups dealing with medicine.

. . . Letters of introduction to foreign medical groups and their members, facilitating professional contacts when traveling abroad.

. . . *The World Medical Journal*, published bi-monthly, and all published studies of W. M. A., with data found nowhere else on scientific, economic, educational and social trends in world medicine.

. . . A certificate of membership, your card to 700,000 doctors of nearly 60 nations joined in a worldwide movement for the highest possible level of medical service.

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I desire to become an individual member of The World Medical Association, United States Committee, Inc., and enclose check for $_____ my subscription as a:

_____Member	$ 10.00 a year
_____Patron Member	$100.00 or more per year
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(Contributions are deductible for income tax purposes)

ON THE RISE!

In one way or another, on one excuse or another, social security tax payments are being boosted every year or two instead of at five-year intervals as originally planned. In 1954, the base was raised from $3600 to $4200. In 1956, the tax rate was increased. Now, Rep. Kean wants to raise the base rate from $4200 to $4800 beginning in 1959. Then in 1960, the tax rate is scheduled to increase ½ per cent for both employee and employer, and ¾ per cent for the self-employed. There is no way of knowing just how expensive social security "insurance" is actually going to be.

March of Medicine Program Praised

MADISON—La Crosse radio station WKBH recently was presented an award for carrying the MARCH OF MEDICINE radio series for a five-year period, as were a number of other stations in Wisconsin.

Commenting on the award and the program, sponsored by the State Medical Society and local county medical societies, the program director of WKBH, Berneice Callaway, said:

"This series is of great help and interest to listeners in this area, and we are very pleased to cooperate with you."

Forty-seven stations in the state carry the weekly health program, now in its 13th year.

FORM COUNCIL FOR HEALTH CARE OF THE AGED

CHICAGO—The foundation was laid recently by some of the most important organizations in the health field to solve the problem of the health care of the aged.

For this purpose, the American Dental Association, the American Hospital Association, the American Medical Association, and the American Nursing Home Association announced the establishment of the Joint Council to Improve the Health Care of the Aged.

Objectives of the council, the formation of which has been under consideration for some time by the sponsoring groups, were announced as:

"(1) To identify and analyze the health needs of the aged; (2) to appraise available health resources for the aged; and (3) to develop programs to foster the best possible health care for the aged regardless of their economic status."

The Joint Council to Improve the Health Care of the Aged is made up of three representatives of each sponsoring organization.

One of the first jobs of the council will be to determine exactly what are the health problems of the aged. Studies have been underway for the past several years by the organizations making up the council, but now, through joint efforts, research will be intensified and projects for meeting the problem will be activated as rapidly as possible. The council will be the agency through which the efforts of the sponsoring member organizations will be coordinated to solve the health problems of the aged.

The sponsoring organizations pointed out that the need for new programs in this field is accented by the fact that the life expectancy of individuals has been constantly increasing in recent years. In 1935 life expectancy in the United States was an average 60.2 years. The most recent figure indicates the average life expectancy now to be 70 years.

The council will have as one of its principal immediate projects the development of programs and facilities to be tailored to the health needs and finances of the aged.

Another facet of the council's broad-range program will be to work closely with health insurance groups in an effort to improve the coverage of the aged and to see that their insurance dollars go further.

It is the belief of the Joint Council to Improve the Health Care of the Aged that much can be done for older people by the states and communities, and the council will endeavor to stimulate the activities at these levels of government.

Special research projects are contemplated by each of the organizations supporting the council. This research will then be pooled and programs developed to meet the health needs of the aged. The ultimate goal is to provide adequate health care at reasonable costs.

HOSPITAL FILM NOW AVAILABLE

MADISON—"For the Love of Life," a new film depicting a general hospital, is now available through the State Medical Society, Box 1109, Madison 1.

LIST CHANGES IN RURAL LIFE

JACKSON, MISS.—Four areas of change in rural society were outlined at the A. M. A. Conference on Rural Health by A. F. Wileden, Ph.D., professor of rural sociology at the University of Wisconsin.

These areas are:

Only 40 per cent of the total American population lived in rural areas in 1950, as compared with 60 per cent in 1900. The farm population had dropped to about 13 per cent of the total population in 1957, and was still steadily decreasing.

Increased technology on the farm accounted for part of the decline. With machines, one farm person can feed six additional nonfarm people.

Farming is no longer viewed as an isolated form of life. It has become more of a business.

The neighborhood, once the strongest unit of social organization in rural America, is dying out. It is now "town-country," with former farmers moving to towns to be nearer their jobs, and city folks moving to smaller towns.

WELCOME TO S.M.S.—To bring out the full meaning of Medical Education Week, the Kenosha County Medical Society brought a busload of Kenosha High School pupils to Madison April 26. They visited the University of Wisconsin Medical School, University Hospitals, the Wisconsin Diagnostic Center and the State Medical Society. They were told of the opportunities in medicine and allied fields, and saw medicine in action. Dr. David N. Goldstein, chairman of the Kenosha County Medical Society Public Relations Committee (third from right), made arrangements for the tour and accompanied the young people, all of whom had indicated an interest in a medical career.

—Rolf Lunde photo.

LEGAL OPINION ON RELEASE OF INFORMATION

QUESTION: MAY A WIDOW CONTEMPLATING A WILL CONTEST AUTHORIZE RELEASE OF INFORMATION IN PHYSICIAN'S OFFICE RELATING TO TESTAMENTARY CAPACITY OF LATE HUSBAND?

MADISON—Recently a member of the State Medical Society asked for an answer to the question above. The answer was prepared by the society's legal counsel as follows:

The answer to this question is no.

We recommend that the physician in question refrain from releasing this information unless with the consent of the deceased husband's executor or administrator. The consent of a Special Administrator is also acceptable. The physician should not release the information without seeing also a certified copy of the Letters of Administration or the Letters Testamentary of the person who professes to act in a representative capacity.

OPINION

This question is controlled by Section 325.21 of the Wisconsin Statutes as construed by the Wisconsin Supreme Court in *Will of King,* (1947), 251 Wis. 269, at 273, and *Will of Bernhard,* (1948), 253, Wis. 521, at 523.

In Will of King, the deceased's father and sole heir-at-law expressly consented to the giving of testimony by the deceased's attending physician in a will contest case. The Supreme Court declared the father incompetent to give such consent, stating that the consent is limited to the personal representative of the deceased. The court said:

> "The rule of evidence prohibiting the admission of a physician's testimony is one which did not exist at common law, and the legislature has been very meticulous in limiting its admissibility. This is not an action by a beneficiary of an insurance policy on the life, health, or physical condition of a deceased person or a person under disability, nor is it an action authorized by law to be commenced in the name of some other person to recover damages for personal injury as provided in clause (4) of the statute in question.
>
> "Here the express consent is limited to the personal representative of the deceased, which in the *Estate of Gallun* (1934), 215 Wis. 314, 254 N.W. 542, was held to mean the executor or administrator of the deceased.
>
> "It is argued that the father, being the sole heir at law, is the personal representative within the purview of the statute. We are unable to agree with this position. If the father were also deceased and the brother and three sisters of the testator were the sole heirs at law, and two of them were contesting the will and two supporting it, it could not be said that any one or all of them qualified as the personal representative of the deceased.
>
> "It is considered the word's 'personal representative,' as used here, mean the executor or administrator of the deceased. The testimony of the witness as to information acquired in attending testator in a professional character necessary to professionally serve him was not admissible, and the objection to all testimony so prohibited should have been sustained."

The foregoing language of the court is particularly valuable on this question inasmuch as it is clearly implied that even though a person might qualify under subsection (4) of Section 325.21 by being expressly mentioned therein as competent to waive privilege on behalf of the deceased, the kind of case that has been brought is a further determining factor. For example, although a widow may be the beneficiary of a life insurance policy and, therefore, qualify under the words of the statute to give consent, she will have the power to give such consent only if the action is one on the policy.

In the will contest case you present for our consideration, only the executor or administrator would have the power to waive privilege.

To the rule set forth in *Will of King*, the *Will of Bernhard* adds the further statutory construction that included under the term "personal representative" is a Special Administrator during the term of his office.

Define Ethics of Clinics

CHICAGO—The Judicial Council of the A. M. A. this spring issued a series of "opinions and reports" to assist various state and county medical societies in their interpretation of the new revised Principles of Medical Ethics, which were adopted by the House of Delegates in June, 1957.

The report following covers the subject of clinics:

"CLINICS"

The Judicial Council has stated before that it does not define terms that may connote ethical or unethical conduct. Nor does it believe it to be within its province to attempt to approve or disapprove, encourage or discourage particular forms of medical practice by definition.

The Principles of Medical Ethics are themselves the criteria by which the ethical nature of professional conduct is determined.

In connection with any definition of the word "clinic", it should be clear that regardless of how clinic is defined, each physician-member of the clinic must act, in his relations with his patients and his colleagues, in accord with all the Principles of Medical Ethics. No physician member of a clinic may permit the clinic to do that which he may not do. Each physician must observe all the Principles of Medical Ethics.

Under the ethical principles of medicine no use may properly be made of the word clinic that would mislead or deceive the public, or would tend to be a solicitation of patients to the particular group of physicians holding themselves out as a "clinic".

SOMETHING FOR NOTHING?

"A dangerous thing about Social Security in the United States," said Ray D. Murphy, president of Equitable Society, "is that the American people have not yet come to realize that more can be given only by taking more. The nation simply does not get something for nothing in Social Security."

Need Medical Personnel to Staff State's Portable Hospital Units

MADISON—Recruitment of physicians, nurses and auxiliary personnel to man the state's 34 new 200-bed hospital units, designed for civil defense emergency use, is a major problem, Dr. Carl N. Neupert, state health officer and co-director of state civil defense health services, said.

This recruiting, he said, will not be as great a problem where the units can be attached to existing hospital service as where they must be maintained independently.

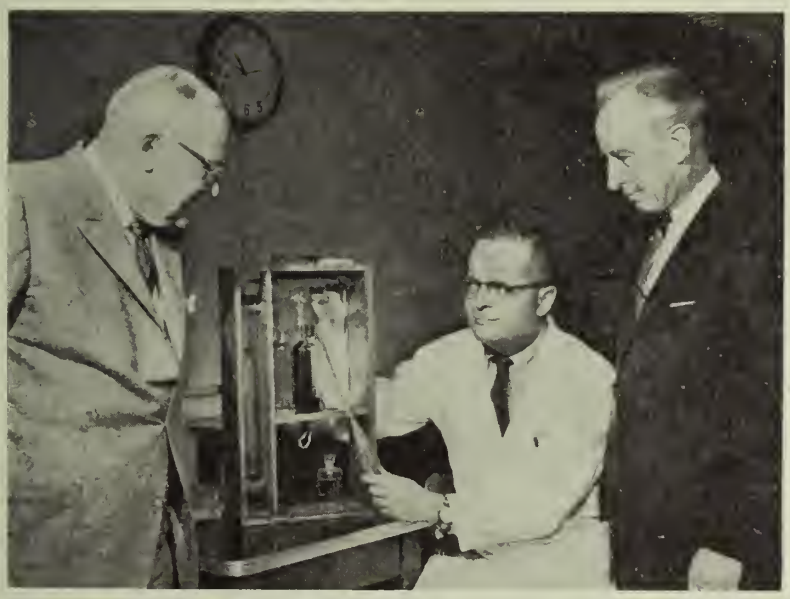
"To be opened only in case of emergency," the units have been placed at strategic points in the state, none within 50 miles of a major target area. The State Medical Society's Civil Defense Committee has worked with Dr. Neupert's office in procuring the units, in working out details for utilization, location and medical team personnel.

The federal civil defense administration provided these units, each valued at $27,000, for installation in hospitals, schoolhouses, or other suitable buildings, to be used in event of disaster. Each unit weighs 12 tons, and contains 200 cots, blankets, three operating rooms, complete x-ray equipment, a pharmacy stocked with essential drugs, and other necessary equipment.

Dr. Neupert said most of the units are presently stored in hospital basements or other convenient locations where they can be put into operation in a hurry on order. Wherever possible, they will be used to extend existing hospital service or to help meet the demand upon such service, he added.

The units are in storage in these communities:

Antigo, Appleton, Beaver Dam, Delavan, Dodgeville, Eau Claire, Fond du Lac (2), Janesville, Menomonie, Monroe, New Richmond, Oconto, Oshkosh (2), Plymouth, Portage, Rice Lake, Spooner, Stevens Point, Two Rivers, Washburn, Waupun, Wausau, Wisconsin Rapids, Jefferson, Gordon, Kohler, Cochrane, St. Croix Falls, Ripon, Plainfield and West Salem.



MADISON—Dr. John Z. Bowers, dean of the University of Wisconsin Medical School, describes an instrument used in the school to Gov. Vernon S. Thomson (right) and Dr. H. E. Kasten, Beloit, president of the State Medical Society of Wisconsin. Before issuing a proclamation marking April 20–26 as Medical Education Week, the chief executive toured the Wisconsin Medical School and observed classrooms and equipment used in the teaching and research program. In his proclamation, Gov. Thomson called upon state residents and health and education agencies "to take appropriate steps to acknowledge our debt to the medical schools and to foster their continuing freedom and security . . . It is our individual responsibility to make sure that our medical schools continue to meet the greater demands of our population." —William Wollin photo.

Get a Tie In the Mail?

MADISON—Do you know what to do with unordered merchandise?

At various times of the year, different groups make appeals for financial assistance of all kinds. Many, of course, are made by reputable organizations, deserving of support. Some are based on emotional appeals with no merit.

The Better Business Bureau of Milwaukee reported an example of one concern known as the Necktie Workers Organization of Wellston, Mo. In its literature, sent along with a tie, were these words:

"All profits we receive from the sale of merchandise go to our handicapped workers for salaries and other benefits."

Its advisory board lists a "physician and surgeon."

Here are the facts:

The so-called physician and surgeon is not licensed to practice medicine in any state, according to the American Medical Association. He claims graduation from a school which was closed after an official investigation revealed that neither the faculty nor the school was adequate for the granting of a degree in medicine.

The Better Business Bureau said that investigation has shown the ties "are made by commercial manufacturers, and less than five per cent of the proceeds are wages paid to handicapped workers."

Persons receiving unordered merchandise are not required to return it, acknowledge receipt of it or pay for it, unless used. It may be kept for a reasonable length of time and if uncalled for, may be destroyed.

EXPAND?

There is not an unlimited number of ways for Social Security to expand. Medical care is one of the few areas not covered by "social insurance," and the present framework of the Social Security Act is adequate to cover socialized medicine by means of a few amendments. The Disability Insurance "Trust" Fund could be changed into a Health Insurance "Trust" Fund by the stroke of a pen. Taxes could be increased. A new title could be added to the law and the private practice of medicine could be virtually destroyed.

CIVIL DEFENSE . . .

(Continued from page 37)

tor of Health Services in Civil Defense, Louis E. Remily, is working with the county societies to obtain medical directors in every county in the near future.

The county medical directors as of May 1:

County *Director*

Brown—Robert J. Rose, M.D., Green Bay
Buffalo—Max O. Bachhuber, M.D., Alma
Dane—Robert F. Schoenbeck, M.D., Stoughton
Dodge—Howard G. Bayley, M.D., Beaver Dam
Fond du Lac—John S. Weir, M.D., Fond du Lac
Green — Benjamin H. Brunkow, M D., Monroe, Charles O. Miller, M.D., Monroe
Jackson—John Krohn, M.D., Black River Falls
Jefferson—Earl J. Netzow, M.D., Lake Mills
Kenosha—Lewis Turner III, M.D., Kenosha
La Crosse—John J. Satory, M.D., La Crosse
Langlade—Robert W. Cromer, M.D., Antigo
Manitowoc—Walter F. Smejkal, M.D., Manitowoc
Marathon—Erwin P. Ludwig, M.D., Wausau
Marinette—C. H. Boren, M.D., Marinette
Milwaukee—Harold E. Cook, M.D., Milwaukee
Oconto—H. A. Aageson, M.D., Oconto
Ozaukee-Washington—J. F. Baumgartner, M.D., West Bend
Polk—Fred B. Riegel, M.D., St Croix Falls
Portage—F. W. Reichardt, M.D., Stevens Point
Price—James J. Leahy, M.D., Park Falls
Racine—W. H. Williamson, M.D., Racine
Richland—Donald J. Taft, M.D., Richland Center
Rock—H. M. Snodgrass, M.D., Janesville
St. Croix—Richard R. Davis, M.D., New Richmond
Shawano—A. J. Sebesta, M.D., Shawano
Sheboygan—Fred A. Nause, Sr., M.D., Sheboygan
Taylor—W. W. Meyer, M.D., Medford
Walworth—Richard J. Rogers, M.D., Elkhorn
Washburn—Dale V. Moen, M.D., Shell Lake
Waukesha—Joseph R. Matt, M.D., Oconomowoc
Waushara—A. A. Beck, M.D., Wautoma

YOUTH HEALTH STRESSED AT FOND DU LAC MEETING

FOND DU LAC—Almost 300 area residents attended a Conference on School Health staged by the Fond du Lac County Medical Society this spring.

Discussions centered around emotional health, physical examinations, physical education programs, rural lunch programs, and scope of health education.

The program was patterned after conferences held at colleges around the state in 1955–1957.

Leading roles in the Fond du Lac conference were taken by Drs. E. H. Pawsat, former chairman of the state society's Division on School Health, and H. J. Kief, member of the society's Council on Medical Service.

NAME ADVISORY C-D COMMITTEE IN MILWAUKEE

MILWAUKEE—The Milwaukee County Office of Civil Defense recently reported that representatives of 12 medical and allied health groups had formed an advisory committee to assist the Medical-Hospital Services division of the Milwaukee Metropolitan Target Area Civil Defense Commission.

Under the chairmanship of Dr Harold E. Cook, the committee has the task of developing and integrating medical disaster planning with state and county plans. The committee also will direct the training of medical and allied health personnel in disaster techniques in conjunction with a familiarization program in utilization of F. C. D. A. emergency 200-bed hospital units.

Currently, the committee is directing the registration with civil defense of all medical and professionally trained personnel in the county.

Racine Society Sets Up Loan Fund For Med Students

RACINE—An interest-free loan fund for medical students in need for financial aid has been created by the Racine County Medical Society.

Dr. W. H. Williamson, society secretary, said the fund would be administered by a committee headed by Dr. W. H. Bennett, vice president of the society.

Loans up to $100 each semester will be available to students attending any accredited medical school. A student is eligible to apply for the financial assistance during any or all of his terms in medical school.

The society will accept gifts and grants from individuals or organizations interested in assisting medical students finance their education, Dr. Williamson said.

The new loan fund was set up by the society as its effort toward observance of Medical Education Week this spring.

New Displays Available Soon

MADISON—Memo to officers of county medical societies!

Does your program for 1958 call for a colorful, educational exhibit at some local event? If it does, consider the new displays being made available through the A. M. A. Bureau of Exhibits, 535 N. Dearborn St., Chicago 10:

"Fight Poisons with Control Centers"
"Your Body"
"How We Breathe"
"We Hear"
"Digestion"
"We See"

To be available in the next few months, these displays employ life-size models, viewer-participation aids, charts and pictures to convey health information to the public.

Other exhibits, covering a wide range of subjects, from accidental poisoning in children, mechanical quackery to testing the drinking driver, are available at the present time.

(The State Medical Society, Box 1109, Madison 1, is also ready to assist in booking the exhibits.)

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 15th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from individual members of the State Medical Society will be accepted without charge. The charge quoted previously applies to advertisements placed by clinics. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.

INTERN DESIRED: Associate wanted in Central Wisconsin community of about 13,000. Address replies to Box 731 in care of the Journal.

OPPORTUNITY FOR ONE, preferably two, physicians in community near Madison, one story building to be constructed to house drug store, dental office and medical offices, parking side and rear of building; village development committee urging this building, eight miles to Madison Hospitals. Contact Box 730 in care of the Journal.

WANTED: Pediatrician, Board certified or eligible, to join established 16-man clinic in Wisconsin community of 40,000. Address replies to Box 722 in care of the Journal.

PHYSICIANS, with or without pediatric training, needed in maternal and child health program at salaries ranging from $8,728 to $10,765. Five-day week, pension, civil service appointment. Address replies to Dr. E. R. Krumbiegel, Milwaukee Health Department, City Hall, Milwaukee, Wis.

WANTED: Physician interested in the care and treatment of the aging. Facilities available for research in the field of geriatrics. Normally, work hours are regularly scheduled. 30 days annual leave, 15 days annual sick leave with pay. Civil Service retirement coverage, low cost group life insurance and other fringe benefits. Inquire Director, Professional Services, Veterans Administration Hospital, Wood (Milwaukee), Wisconsin.

WANTED: GENERAL PRACTITIONER: Two general practitioners in northwest Wis. desire association of a third physician, full partnership assured after one year, good hospital facilities. Write or phone LE 7-5377, Barron, Wis. m5-6

FOR SALE: Lightning Electro-therapy machine, Tycos blood pressure gauge, Fleischer stethoscope, Brown sphygmomanometer, various surgical instruments, sprays, flasks, test tubes and other glassware. (equipment of deceased M.D.) GA-5-5587; 9515 W. Carpenter Ave., Milwaukee, Wis.

EXCELLENT OFFICE OR CLINIC LOCATION AVAILABLE in shopping center at 13817 W. National Ave., Milwaukee 19, Wis., town of New Berlin, 14000 Pop., presently without resident physician. Inquire New Berlin Pharmacy at above address.

WANTED: Locum tenens for month of June. Includes liberal income and living quarters. Address replies to Lorne A. Campbell, M.D., Clear Lake, Wisconsin.

WANTED: Physicians interested in general and specialty practice are urgently needed in Watertown, Wisconsin, due to several physicians leaving for specialty training. Town 15,000 population. Hospital privileges available. Will give assistance in obtaining office space. Information available by contacting: Chief of Staff, St. Mary's Hospital, Watertown, Wisconsin.

LOCUM TENENS OR M.D. ASSISTANT POSITION WANTED: Available July. Completing GP residency. Address replies to Box 729 in care of the Journal.

LOCUM TENENS AVAILABLE: Wisconsin licensed physician available for one month during May, June or July to do general practice. Will need few day's notice. Now at University Hospitals, Madison. Address replies to Box 727 in care of the Journal.

LOCUM TENENS: Resident in surgery desires locum tenens for two months (July and August) to do general practice and surgery. Contact Theodore S. Roberts, M.D., University of Wisconsin General Hospital, Madison, Wisconsin.

WANTED: Young, white, male M.D. for surgical assistant and also general practice in 16 man medical group. This is a one or two year appointment beginning July 1, 1958, and is a good opportunity to obtain training under qualified men. Write giving resume and salary expected to Midelfart Clinic, Eau Claire, Wisconsin.

OFFICE AVAILABLE IN MEDICAL ARTS BUILDING: A modern medical office for private practice is available for immediate occupancy, in an established MEDICAL ARTS BUILDING. Located in a northern Wisconsin city of 10,500, and includes an area of 30,000 people, two fully accredited hospitals. Excellent opportunity. Address replies to Box 725 in care of the Journal.

LOCUM TENENS WANTED for 2-3 weeks of Sept. 1958. Contact Dr. J. G. Pellicer, 2919 No. 50th St., Milwaukee 10, Wisc.

DOCTORS' OFFICE SPACE AVAILABLE in beautiful new Brentwood Medical Arts Building, 2018 North Sherman Avenue, Madison. Private doctors' parking, public parking (40 cars), acoustical ceiling, mahogany paneling, heat and air conditioning, large reception room, black top parking area, pharmacy in building. On bus line, convenient to schools and churches. Address replies to Box 715 in care of the Journal.

FOR RENT—IN MILWAUKEE: All or part of 2,200 sq. ft. medical suite for one or more physicians. Located on second floor above pharmacy. Heated. Will remodel or redecorate to suit. Excellent location—corner 27th and Lisbon Ave. This area greatly in need of doctors. Physician has had established medical practice for 32 years. Call Broadway 6-4421, Mrs. F. Gute.

FOR SALE: Large going general surgery and general practice by surviving partner. City of 100,000. Introduction included. Will also sell surgical instruments, office equipment and furniture. Address replies to Box 728 in care of the Journal.

FOR SALE: 43 year active general and industrial practice. Includes 12 room home and fully equipped office, unlimited parking. Will introduce 3-6 months. Retiring. Price: $35,000. Address replies to Box 724 in care of the Journal.

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Riseman, J. E. F., Altman, G. E., and Koretsky, S.: Nitroglycerin and Other Nitrites in the Treatment of Angina Pectoris, Circulation (Jan.) 1958.

* 'Cardilate' brand Erythrol Tetranitrate SUBLINGUAL TABLETS, 15 mg. scored

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OBITUARIES

Dr. Joseph E. Reichert, a retired West Bend physician, succumbed November 25. He was 95 years of age.

Doctor Reichert was born at Mequon in 1862. Prior to entering medical school he taught school at Cedarburg and Port Washington and served as Ozaukee school superintendent. In 1891 he graduated from Rush Medical College, Chicago, and began his first practice at Slinger where he was located for 19 years. Doctor Reichert then re-entered Rush for two years of medical research, returning to Wisconsin at the completion of his work to practice at West Bend. He retired 14 years ago.

For a number of years he was a member of the State Medical Society of Wisconsin, the Washington–Ozaukee County Medical Society, and the American Medical Association.

Immediate survivors are his wife, Barbara; a physician son, Dr. John L., Chicago; and two daughters, Mrs. Harold Smedley, Muskegon, Michigan, and Mrs. Robert Borsen, Ashland.

Dr. R. R. Rath died December 12 at the age of 73. He had been a Granton general practitioner for 52 years.

Born in 1884 at Sparta, he graduated from Marquette University School of Medicine in 1906. Prior to locating in Granton, Doctor Rath practiced for a short time at Taylor. In 1936 he founded the Granton Clinic, but was forced to discontinue the clinic work when he went into semi-retirement due to permanent injuries incurred in an automombile accident in 1939.

Doctor Rath was a former member of the Clark County Medical Society for which he served terms as president and secretary, the State Medical Society of Wisconsin and the American Medical Association.

He is survived by his wife, Hazel.

Dr. J. J. Werner, 44, died January 2 in Milwaukee, his place of practice.

He was born in 1913 at Sheboygan, graduated from Marquette University School of Medicine in

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1939, interned at Mount Sinai Hospital, and served residencies at Deaconess and Johnson Emergency Hospitals in Milwaukee. From 1941 to 1943 Doctor Werner served as a captain in the Army medical corps and returned to Milwaukee to establish a practice. He was on the medical staffs of Deaconess, Mount Sinai and Doctor's Hospitals.

Doctor Werner was a member of the State Medical Society of Wisconsin, the Medical Society of Milwaukee County, the American Medical Association, the American Academy of General Practice, and was president of the Mount Sinai Interns' Alumni Association.

Among those surviving are his wife, Roberta; a daughter, Toby; and a son, Jeffrey.

Dr. T. S. O'Malley, Milwaukee, died January 9 at the age of 65.

A native of Wisconsin, he was born at Waunakee in 1892. Doctor O'Malley attended the University of Wisconsin Medical School and was a 1918 graduate of Columbia University College of Physicians and Surgeons. In 1920, following an internship and residency at Staten Island Hospital, New York, he returned to Wisconsin to begin practice at Milwaukee. Besides having a private practice, Doctor O'Malley was director of the medical department at the A. O. Smith Corporation for 34 years. He retired last October.

He was a member of the State Medical Society of Wisconsin, the Medical Society of Milwaukee County, the American Medical Association, the American College of Surgeons, the Wisconsin Surgical Society and the Milwaukee Academy of Medicine.

His wife, Orpha, and two sons, Thomas, Jr., Chicago, and Doctor Richard, practicing in Milwaukee, survive.

Dr. Howard T. Hansen, Milwaukee, died February 5 at the age of 57.

Born in 1900 at Milwaukee where he spent virtually his entire life, Doctor Hansen received his

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medical degree from Marquette University School of Medicine in 1928. He served an internship at Milwaukee County Hospital the following year.

Doctor Hansen was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include a daughter, Sally, and a son, Peter, both of Milwaukee.

Dr. W. F. Lorenz, 76, a widely-known Madison psychiatrist, died February 18.

Doctor Lorenz was born in New York in 1882 and received his medical degree in 1903 from New York University College of Medicine. He also served an internship and a residency in the state of New York. He was described as "Wisconsin's pioneer in the field of preventive psychiatry", having moved to Wisconsin in 1910. Doctor Lorenz accepted an appointment in 1915 as director of the Wisconsin Psychiatric Institute shortly after joining the staff of the University of Wisconsin Medical School. He served, too, as chairman of the old Wisconsin State Board of Control which supervised all state institutions for a few years, and he was president of the Wisconsin Rehabilitation Board. Doctor Lorenz was an emeritus professor at the University of Wisconsin at the time of his death. After his retirement in 1952, he moved to Gordon, but remained active in many civic affairs.

He was a member of the American Psychiatric Society, and the Central Neurology and Psychiatry Society, was certified by the American Board of Psychiatry and previously was a member of the Dane County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Among the survivors are his wife, three sons, and a step-son.

Dr. S. C. Allen of Waterloo passed away February 26 at the age of 67.

Doctor Allen was born in 1890 at Milwaukee, graduated from Marquette University School of Medicine in 1914, and interned at Milwaukee County Hospital. Before moving to Waterloo, he served a one year residency at St. Joseph's Hospital, Milwaukee. During his more than 40 years as a general practitioner at Waterloo he became active in public and civic affairs.

Memberships held by Doctor Allen at the time of his death included those with the State Medical Society of Wisconsin, the Jefferson County Medical Society, and the American Medical Association.

Surviving are his wife, Mercy, and a son, Robert, living in Shorewood.

* J.A.M.A. *166*:158,1958; Welsh,A.L. and Ede,M.
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*
1. Clyman, S. G.: Postgrad. Med. *21*:309, 1957.
2. Bleiberg, J.: J. M. Soc. New Jersey *53*:37, 1956.
3. Abrams, B. P., and Shaw, C.: Clin. Med. *3*:839, 1956.
4. Welsh, A. L., and Ede, M.: Ohio State M. J. *50*:837, 1954.
5. Bleiberg, J.: Am. Practitioner *8*:1404, 1957.

Dr. P. F. Brey, a Milwaukee physician and surgeon, passed away March 22 after a long illness. He was 79 years of age.

A native of Wisconsin, Doctor Brey was born at Algoma in 1879. After graduation from Marquette University School of Medicine in 1910, he located in Milwaukee. In addition to his medical practice, Doctor Brey was a professor of pharmaceutical botany and an instructor in pathology at Marquette. Fifteen years ago he went into semi-retirement because of ill health.

He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his daughter, Mrs. C. P. Kuss, with whom he was living at the time of his death, and two sons, Father Lawrence, Kenosha, and Jerome, Milwaukee.

Dr. Charles Fidler of Milwaukee, a former president of the State Medical Society of Wisconsin, passed away March 27 after a lingering illness. He was 77 years of age.

Dr. Charles Fidler

Born in 1880 at Newman, Illinois, he was a 1906 graduate of Rush Medical College. Doctor Fidler interned at Chicago Emergency Hospital and at St. Mary's Hospital, Milwaukee. A residency in surgery was completed by him at Milwaukee's Johnston Municipal Hospital.

While practicing in Milwaukee, he was chief of staff at St. Mary's Hospital in 1933 and of the County General Hospital in 1935, was a member of the staff at Columbia Hospital, was chief of the department of surgery at St. Mary's Hospital, and was an honorary member of the staff at Milwaukee Children's Hospital. In 1943 Doctor Fidler received recognition for a quarter century as associate clinical professor of surgery at Marquette University School of Medicine.

He was a member of the State Medical Society of Wisconsin, the Medical Society of Milwaukee County, the American Medical Association, the Fifty Year Club, and the Milwaukee Academy of Medicine from which he received an honorary membership in 1949 after 35 years of participation as a member. In 1928, he was secretary of the old Wisconsin Surgical Society which disbanded in 1929. He was also a fellow of the American College of Surgeons. Besides being president of the State Society in 1944, he served a term in 1934 as president of the Milwaukee County Society.

Doctor Fidler is survived by his wife, Rose.

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WM-558

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News Items and Personals*

Sixth Councilor District Meeting

Dr. G. P. Schwei, Menasha, was moderator of the Sixth District Councilor District meeting held April 17 at the Elks Club in Menasha. The welcome address was given by *Dr. G. W. Carlson*, Appleton. The afternoon scientific program consisted of a talk given by *Dr. E. J. Zmolek*, Oshkosh, on "Surgical Management of Carcinoma of the Esophagus", a lecture on "Pediatric Problems in Everyday Practice" by *Dr. T. V. Geppert*, Madison, a panel composed of *Drs. E. S. Gordon*, Madison, *E. J. Zmolek*, *T. V. Geppert*, Madison, and *Ernest Strakosch*, Oshkosh, who discussed "Present Status of Steroid Therapy", and a speech presented by *Dr. F. J. Millen*, Milwaukee, entitled "Differential Diagnosis of Headache."

Following the program a meeting was held for the delegates and alternates and in the evening those attending heard Doctor Strakosch outline "The Historical Development of the Middle East and Its Relationship to the Current Crisis."

* Physicians whose names are printed in italics are members of the Society.

Dr. Stovall Guest Speaker

Dr. W. D. Stovall, of Madison, chairman of the campaign for the Medical Museum, was a guest speaker at a meeting of the Fourth Councilor District on April 24 at Blue Heaven, Prairie du Chien. The meeting was also attended by staff of the State Medical Society who discussed various matters which were to come before the House of Delegates at the annual meeting beginning May 5.

West Point M. D. Located in Clark County

Dr. George Nemec, Jr., a former physician-surgeon on the staff of West Point Hospital, New York, is an associate of *Dr. William A. Olson* of Greenwood. Doctor Nemec's departure from West Point took place early in April and he commenced practice in Greenwood during the latter part of the month, sharing the office and facilities of Doctor Olson.

While serving his term at the West Point Hospital, Doctor Nemec was in charge of the ear, nose and throat clinic, including the surgery in this de-

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partment. He also has been on various other services, including obstetrics, orthopedics and general surgery.

He is a 1954 graduate of the University of Illinois College of Medicine and served an internship and residency at Presbyterian–St. Luke's Hospital in Chicago. He was also a resident physician at Chicago Municipal Contagious Hospital and at Hine VA Hospital, serving in the internal medicine department. He was stationed at Brooke General Hospital, Fort Sam Houston, Texas, before being assigned to West Point.

PTA Hears Doctor Zach

Dr. Robert G. Zach, radiologist at the Monroe Clinic, talked at the Monroe "Dad's Night" program on March 27. The doctor told of his tour through the Atomic Energy Commission testing sight in Nevada and described his experiences in witnessing an atomic explosion. The lecture, which was illustrated with colored slides, was followed by a question and answer period.

Dr. Neisius to Serve Baraboo

The practice of *Dr. B. E. McGonigle* who left Baraboo in April to assume duties in his new position in the Napa, California, mental hospital, has been taken over by Dr. Frank A. Neisius. Doctor Neisius is a 1928 graduate of Creighton University School of Medicine and was practicing in Stayton, Oregon, before moving to Baraboo.

Wausau Dermatologist Speaks to Hairdressers

Dr. William Miller, a Wausau dermatologist, was the guest speaker at the March 17 meeting of the Rib Mountain Hairdressers. His talk on diseases more commonly confronted by the cosmetologist was augmented with slides.

New Green Bay Clinic Open

A new brick and concrete one-story building has been completed for the new site of the Green Bay Clinic. The 56-room clinic, which has been completely furnished with new equipment, contains two minor surgery rooms and facilities for deep x-ray therapy. It was announced that expansion of the clinic staff is being considered. In compliance with past policies all new physicians employed will be trained at the Mayo Clinic for special training in clinic practice.

La Crosse Hospital Names Officers

In April the medical staff of La Crosse Hospital elected the following officers: *Drs. E. P. Rohde*, president; *J. R. Richter*, vice-president; and *C. B. Moen*, secretary–treasurer.

During the session it was noted by *Dr. M. J. Watunya*, chief of the medical staff, that new members added to the staff during the year include: Drs. *W. A. Himmelsbach, L. M. Gorenstein, B. E. Lloyd, D. L. Morris*, P. H. Utz, and *Kaare Getz.*

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Ethinyl Estradiol	0.01 mg.	Riboflavin	2 mg.
Ferrous Sulfate	50 mg.	Pyridoxine Hcl.	0.3 mg.
Rutin	10 mg.	Niacinamide	20 mg.
Ascorbic Acid	30 mg.	Manganese	1 mg.
B-12	1 mcg.	Magnesium	5 mg.
Molybdenum	0.5 mg.	Iodine	0.15 mg.
Cobalt	0.1 mg.	Potassium	2 mg.
Copper	0.2 mg.	Zinc	1 mg.
Vitamin A	5,000 I.U.	Choline Bitartrate	40 mg.
Vitamin D	400 I.U.	Methionine	20 mg.
Vitamin E	1 I.U.	Inositol	20 mg.
Cal. Pantothenate	3 mg.		

Write for Latest Technical Bulletins.

*REFERENCE: J.A.M.A. 163: 359, 1957 (February 2)

S. J. TUTAG & COMPANY TUTAG DETROIT 34, MICHIGAN

Med Techs Hear Dr. Philip Piper

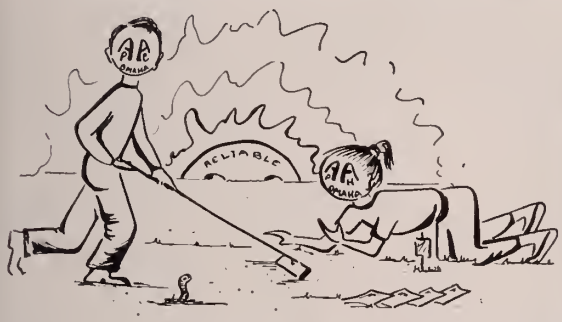
"Correlation Between Bone Marrow and Peripheral Blood Smears" was the topic of a speech delivered by *Dr. Philip Piper*, pathologist at Madison General Hospital, to the members of the Southern Wisconsin Medical Technicians Association at a meeting in March. Colored slides from cases of multiple myeloma, polycythemia, anemias, leukemias, and other abnormal blood conditions were shown by the doctor.

Dr. Supernaw Presents Lecture

Dr. J. S. Supernaw, Madison, chose the subject of "Health in the Dental Office" for a talk given February 26. He addressed the Madison Dental Hygienists Association during their meeting held at the Cuba Club.

Dr. Gordon Speaks in Chicago

A Professor of Medicine at the University of Wisconsin Medical School, Dr. Edgar S. Gordon, addressed members of the Chicago Medical Society at their annual clinical conference held in March. In his lecture concerning hardening of arteries, he pointed out that there is accumulating evidence that stress, rather than diet, may play the more important role in this condition. He stated that this is concluded from the fact that healthy persons under stress of everyday living, such as students during examinations and business executives under extreme tension, can boost the level of blood cholesterol. "Actually," he said, "the amount of cholesterol in the diet is of very little importance since most of this compound circulating in the blood stream comes from internal synthesis from simple chemical compounds present in the tissues of normal subjects in great abundance."



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Cosmopolitan Club of Milwaukee Provides Free Services to Needy

A plastic surgery program initiated by the Cosmopolitan Club of Milwaukee, developed four years ago, has set a precedent for like organizations throughout the country. As a result of the Club's efforts, approximately 100 disfigured persons, not able to afford plastic surgery, have been provided plastic, reconstructive surgery.

Under its program, the Club pays the hospital bills, and the surgery is donated by *Dr. V. B. Hyslop*, a member. To date the estimated cost for these services has totaled around $20,000.

Milwaukee County Hospital Has Annual Meeting

On April 26 the Milwaukee County Hospital Intern and Resident Association held its annual meeting at the hospital. Guest speaker for the occasion was *Dr. O. O. Meyer*, Professor of Medicine and Chairman of the Department of Medicine at the University of Wisconsin Medical School. He spoke on "Some Newer Aspects of Treatment of the Leukemias and Lymphomas." The following Milwaukee physicians were also on the program: *L. W. Worman*, "The Treatment of Patients with Acute Perforation of Peptic Ulceration"; J. J. Schechter, "The Colon as Replacement for the Esophagus; Its Resistance to Reflux of Gastric Juice"; *Paul Natvig*, "Open Reduction of Facial Fractures"; *J. D. Selzer*, "Gallstone Ileus"; *T. J. Foley*, "Cut Downs"; and *V. P. Simmons*, showed a movie on "Modern Concept of Thymic Physiology". Dr. W. F. Mazzitello of St. Paul, Minnesota, lectured on "Diagnosis of Interatrial Septal Defects by Cardiac Catheterization, Cuvette-Oximetry, and Dye Dilution Curves."

Following lunch and a business meeting those who wished attended the Philadelphia vs. Milwaukee baseball game. In the evening a dinner dance was given at the Wisconsin Club.

(Continued on page 60)

POSTGRADUATE MEETING

The second postgraduate meeting to be held this spring by the Jackson Clinic and Foundation will take place Thursday, May 29. In addition to the Jackson Clinic Staff who will take part in the program, Dr. J. Donald Hare, from the department of pediatrics at the State University of Iowa, will be a guest speaker.

"Rheumatoid arthritis is a constitutional disease with symptoms affecting chiefly joints and muscles."[1] "Pain in the affected joint is accompanied by splinting of the adjacent muscles, with resultant 'muscle spasm.' "[2]

rheumatoid arthritis involves both joints and muscles only

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SUPPLIED: Multiple Compressed Tablets in bottles of 100, in three formulas:
MEPROLONE-5—5.0 mg. prednisolone, 400 mg. meprobamate and 200 mg. dried aluminum hydroxide gel.
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MEPROLONE-1—supplies 1.0 mg. prednisolone in the same formula as MEPROLONE-2.

1. Comroe's Arthritis: Hollander, J. L., p. 149 (Fifth Edition, Lea & Febiger, Philadelphia, Pa. 1953).
2. Merck Manual: Lyght, C. E., p. 1102 (Ninth Edition, Merck & Co., Inc., Rahway, N. J. 1956).

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When tetracycline therapy is indicated—

3 INDISPUTABLE POINTS

References: 1. Council on Drugs, A.M.A.: J.A.M.A. 166:52, 1958. 2. Pulaski, E. J.: Practitioner 179:465, 1957. 3. Cronk, G. A., and Naumann, D. E.: Ant. Med. & Clin. Ther. 4:166, 1957. 4. Kaplan, M. A., Dickison, H. L., Hubel, K. A., and Buckwalter, F. H.: Ibid. 4:99, 1957. 5. Prigot, A., Shidlovsky, B. A., and Felix, A. J.: Ibid. 4:287, 1957. 6. Pulaski, E. J., and Isokane, R. K.: Ibid. 4:408, 1957. 7. Putnam, L. E.: Ibid. 4:470, 1957. 8. Rein, C. R., and Fleischmajer, R.: Ibid. 4:422, 1957. 9. Welch, H., Lewis, C. N., Staffa, A. W., and Wright, W. W.: Ibid. 4:215, 1957. 10. Cronk, G. A., Naumann, D. E., and Casson, K.: Antibiotics Annual, 1957-8, ed. by H. Welch and F. Marti-Ibanez, Medical Encyclopedia, New York, p. 397. 11. Dube, A. H.: Ibid. p. 409. 12. Hubel, K. A., Palmieri, B., and Bunn, P. A.: Ibid. p. 443. 13. Kaplan, M. A., Albright, H., and Buckwalter, F. H.: Ibid. p. 415. 14. Portney, B., Draper, T., and Wehrle, P. F.: Ibid. p. 386. 15. Shidlovsky, B. A., Prigot, A., Maynard, A. de L., Felix, A. J., and Hjelt-Harvey, I.: Ibid. p. 459.

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1 Tetrex requires no "activating additive"

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— over 5000 human blood determinations after oral or intramuscular administration have consistently demonstrated fast, high, prolonged serum levels in patients of all ages.[3,5,6,7,8,9,10,11,12,13,14,15]

3 Tetrex has an impressive documented record of clinical effectiveness

— more than 170 million doses of tetracycline phosphate complex in 1957, with 5 published clinical reports by 9 investigators on 826 patients.[3,5,7,8,10] *Clinical evaluation:* "should probably be considered an improvement over, and an ultimate replacement for, the older tetracycline hydrochloride."[10]

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(Continued from page 55)

Patients Honor Doctor Nowack

Dr. Louis W. Nowack, who left April 1 from Watertown to take up residency at Bowling Green, Ohio, was honored on two occasions as farewell gestures by his patients.

The first was a testimonial dinner held March 9 in the Legion Green Bowl at Watertown. One hundred and twenty-four persons attended the surprise event to express their appreciation for the services rendered to them and to their families. A gift was presented to Doctor Nowack and a corsage to Mrs. Nowack. In addition, Doctor Nowack received a scrap book which contained pictures of a large number of the babies he delivered during his practice in Watertown since 1946 when his father retired from active practice.

On March 16, a second group of patients honored Dr. and Mrs. Louis W. Nowack, also Doctor Nowack's mother, Mrs. Clara Nowack, who was a guest of honor. A gift was presented to the departing couple.

Doctor Nowack is now one of two physicians in charge of the Bowling Green State University's 24-bed hospital.

Dr. Cauldwell Presents Paper

A scientific paper on the anatomy and embryology of major vein anomalies was read by *Dr. E. W. Cauldwell* at the annual meeting of the American Association of Anatomists in Buffalo, New York, during April. Doctor Cauldwell is pathologist at Beloit Hospital.

Open House Series at Racine Curative Workshop

The newly expanded Curative Workshop at Racine has held a series of open house sessions recently. The first session was held for members of the Racine County Medical Society on March 27. The Workshop played host to a national rehabilitation meeting on March 28 and 29. Staff members of Racine Community Chest agencies, other social welfare groups, insurance claim agents and industrial nurses attended an open house at the Workshop on April 10, and, on Sunday, April 20, the general public toured the Workshop's new facilities at an open house. Workshop staff and board members explained services offered by the center.

The Workshop, with its $250,000 addition and remodeled main quarters, is located at 2335 Northwestern Ave.

New Position For Wisconsinite

A native of Wisconsin, Dr. Eugene R. Jolly, has been appointed assistant director of the New Drug Branch of the Bureau of Medicine of the Food and Drug Administration, according to a recent release by the U. S. Department of Health, Education and Welfare.

Doctor Jolly is a native of Oconto, Wis., and received a B.S. degree in pharmacy and a Ph.D. degree in pharmacology from the University of Wisconsin. He taught pharmacology at the University of Michigan School of Medicine and received his M.D. degree from that institution in June, 1957.

New UW Medical School Staff Members

Dr. David T. Graham has joined the staff of the University of Wisconsin Medical School in the capacity of associate professor of medicine. He is teaching and doing research in the field of psychosomatic medicine.

Doctor Graham is a native of Mason City, Iowa. He obtained a master's degree in psychology at Yale University in 1941 and studied in the Yale School of Medicine for two years, going to Washington University School of Medicine to complete work for his M. D. degree. This was granted in 1943.

In 1944 he interned at the Barnes hospital. He became a resident in the same year, served with the Army for two years, then returned to the hospital in 1947. The following year he became a research fellow in medicine, Cornell University Medical College, and in 1951 returned to Washington University as an assistant professor of medicine.

He is the author of a number of technical publications in the field of psychosomatic medicine and also serves as editor of the technical journal, *Clinical Research Proceedings.*

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July 7–19, 1958 **October 13–25, 1958**

The United States Section of the International College of Surgeons will again offer its Annual Postgraduate Course, in cooperation with the Cook County Graduate School of Medicine. It will be a two-week intensive review course in General Surgery presented at the Graduate School, and in the wards and operating rooms of Cook County Hospital. Because the course has been oversubscribed in previous years, it will be offered twice in 1958.

The program will be offered under the supervision of the Hospital's Surgical Staff. It will include illustrated lectures, motion pictures, anatomy demonstrations, operative clinics and practice surgery by the participants on anesthetized dogs. Consideration will be given not only to surgical technic, surgical complications and management of the surgical patient, but also to an intensive review of the basic sciences in relation to clinical surgery. In addition to twenty hours of surgical anatomy on the cadaver, the program will include lectures and demonstrations on various aspects of general surgery.

The course will consist of 78 hours of instruction, and participants will be eligible for formal (Category I) credit from the American Academy of General Practice.

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The appointment of *Dr. Halvor Vermund* to the radiology faculty of the University of Wisconsin Medical School has been announced. Doctor Vermund came to Wisconsin from the University of Minnesota Medical School's department of radiology.

A native of Norway, Doctor Vermund obtained his medical degree at Oslo in 1943 and took his residency training in the department of surgery at the Halden, Norway, hospital.

Doctor Vermund came to this country and the University of Minnesota in 1948. He was granted the doctorate in radiology in 1951 and worked as a research fellow and research associate until 1953, when he was made an assistant professor. He became an associate professor at Minnesota in 1956.

Dr. Samp Gives Talks

Dr. R. J. Samp of the University Hospitals, Madison, recently presented two talks on the topic of cancer, one in Appleton and one in Fond du Lac.

Speaking to the Fond du Lac County unit of the American Cancer Society on March 19, he gave an up-to-the-minute report on what progress has been made in fighting cancer. On April 2, he discussed newest research developments in cancer when he spoke to the Outagamie County unit of the American Cancer Society.

Tormey, Jr., Joins Tormey Clinic

Drs. A. R. Tormey and *G. A. Benish*, Madison, recently announced that *Dr. A. R. Tormey, Jr.*, has joined them in the practice of medicine at the Tormey Clinic. A 1949 graduate of the University of Wisconsin Medical School, Doctor Tormey, Jr., interned at Passavant Memorial Hospital, Chicago; studied a year at the University of Pennsylvania Post Graduate School; and served a three-year residency in urology at Washington University, St. Louis. For the past two years he had been on active duty with the Air Force Medical Corps in Japan.

THIRD AND TWELFTH DISTRICTS NEWS

Dr. Parsons Gives Talks

Dr. William B. Parsons, Jr., of the department of internal medicine at the Jackson Clinic, Madison, participated in a symposium on "Clinical Approaches to the Treatment of Atherosclerosis" at the annual meeting of the Public Health Service Clinical Society at Bethesda, Maryland, on April 25. The title of his talk was "The Treatment of Hypercholesterolemia with Nicotinic Acid."

Doctor Parsons will also address the Illinois State Medical Society May 22 on "The Management of the Hypercholesterolemic Patient."

Poison Center Started in Madison

In April a new Poison Information Center designed to serve the entire state of Wisconsin commenced operation at the University of Wisconsin Hospitals. It is believed that Wisconsin is the fifth medical school in the country to establish such a center and is one of few centers serving an entire state. The Center, which is located in the department of pediatrics in the children's unit of the hospital, will provide services limited to information to citizens through their physicians.

The Dane County Medical Society, a prime mover in the Center's establishment along with the Madison Board of Health, the State Board of Health, and the State Medical Society, is donating the reference library that will be the main source of information for the Center.

Dr. Stuesser Joins Quisling Clinic

It was recently announced that *Dr. Glen J. Stuesser* is associated with the Quisling Clinic in Madison. Doctor Stuesser is a 1953 graduate of the University of Wisconsin Medical School and completed a residency at Madison General Hospital just prior to affiliating with the clinic.

Dr. Ganser Talks to Kiwanis

An explanation of the operations and functions of the Wisconsin Diagnostic Center in Madison was given by Dr. Leonard J. Ganser when he spoke to the local Kiwanis East Club meeting in March. He is the superintendent of the Center.

Dr. Taborsky Takes Surgery Course

In April *Dr. C. R. Taborsky* of Madison participated in a postgraduate course in reconstructive nasal surgery. The session was held at the University of Cincinnati College of Medicine and the Cincinnati General Hospital.

Madison Doctors Attend Medical Convention

A four-day national convention of the American Academy of General Practitioners was attended by *Drs. J. G. VanGemert, J. G. Waddell, G. A. Benish,* and *T. J. Nereim*, all of Madison. The meeting was held in Dallas, Texas.

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1. Russek, H. I.: Postgrad. Med. *19*:562 (June) 1956.

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Dr. Freund Addresses Kiwanis

A Beaver Dam general practitioner, *Dr. Richard Freund*, was the main speaker at the March 24 meeting of the Watertown Kiwanis Club. His discussion covering "Juvenile Problems" urged that those interested in helping children with problems begin early enough to be of real help. He also asked that the members offer themselves as "friends to young people with problems". A group of this nature has been developed in Beaver Dam, he said, and some worthwhile things have developed as a result.

Dr. Marshall Opens Blanchardville Clinic

Dr. H. B. Marshall, who has been a practicing physician in Hollandale for nearly 25 years, held open house in his new clinic building in March. The clinic is a one-story structure made of redwood and lannon stone.

Dr. Boyd Practicing in Platteville

Dr. F. E. Boyd, formerly of Edgerton, has established an office in Platteville. He is associated with *Dr. H. L. Doeringsfeld* of that city. A graduate of Harvard Medical School, Doctor Boyd worked at the Boston City Hospital for two years and then spent six months in a rotating residency at Montgomery County Hospital, located outside of Philadelphia.

Kewaskum Physician Receives Novel Gift from Welsh Relatives

Dr. R. G. Edwards, Kewaskum, recently received a "loving spoon" from relatives in Wales. They sent it to him upon his inquiry after he heard on a television program about the custom of giving these spoons. Carved from wood, the spoons are given to girls instead of engagement rings. The custom originated many years ago because of poorer residents' lack of funds to purchase engagement rings. The practice grew in popularity and still continues today.

Krohn Clinic Extends Services to Alma Center

Since November, *Dr. R. M. Thurow* of the Krohn Clinic, Black River Falls, has been holding office hours every Tuesday afternoon in Alma Center. Dr. John Krohn is serving the community with office hours on Friday mornings.

This is the second extension of service of the Black River Falls clinic, the first being the opening of offices in Melrose. Drs. John Marks and *J. H. Noble* have office hours there.

Dr. Apell Addresses Mothers Group

At a recent meeting of the Omro Mothers Club, *Dr. M. G. Apell*, Oshkosh, addressed the group on the subject of "How Healthy Are Our Children?" The meeting was held in the local elementary school.

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The reasons are fairly simple. Doctors like "Premarin," in the first place, because it really relieves the symptoms of the menopause. It doesn't just mask them – it replaces what the patient lacks – natural estrogen.

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supplied: 10, 25 and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

references: 1. Strub, I. H.: Personal communication. 2. Ayd, F. J., Jr.: presented at Ohio Assembly of General Practice, 7th Annual Scientific Assembly, Columbus, September 18-19, 1957.

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Montfort Office Opened by Dr. Breier

Having recently completed a year of internship at Madison General Hospital, Dr. Harold P. Breier has opened an office at Montfort for the practice of medicine. The doctor was born in Indonesia of Dutch parentage. Following World War II he moved to Amsterdam, Holland. Doctor Breier received his medical education at the University of Amsterdam, graduating in 1953, and interned in that city for two years. He entered this country in February, 1957, and came immediately to Madison to begin the internship necessary to obtain a state license.

"Morals, Men and Medicine" Discussed at Neenah Club

A discussion on the moral responsibilities of doctors and laymen was given by *Dr. George Schwei* and Rev. Norman Ream during a February meeting of the Neenah Club. The subject, covering birth control, sterilization, euthanasia, artificial insemination, charging extremely high fees, post mortem examinations, and many other controversial problems facing the doctor and patient, was summed up when Doctor Schwei stated that a doctor who practices good and honest medicine has nothing to fear.

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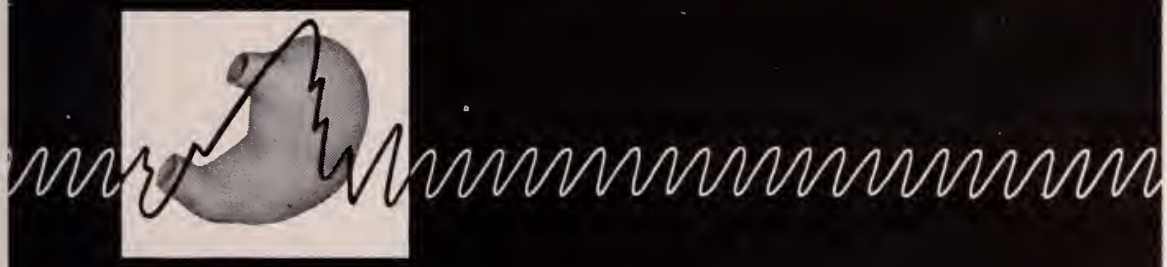

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Society Records

New Members

J. A. Spector, V.A. Hospital, Wood.

Roman Bilak, 2730 North 48th Street, Milwaukee.

Craig Larson, 3467 North Humboldt Avenue, Milwaukee.

R. W. Wilhoite, 2320 North Lake Drive, Milwaukee.

Raymond Harkavy, Cleveland Clinic, 2020 East 93rd Street, Cleveland, Ohio.

J. H. Casey, 161 West Wisconsin Avenue, Milwaukee.

A. J. MacGillis, 2365 South Kinnickinnic Avenue, Milwaukee.

S. A. Marks, 161 West Wisconsin Avenue, Milwaukee.

W. W. Wersich, 324 Board of Trade Building, 1507 Tower Avenue, Superior.

W. J. Gallen, 721 North 17th Street, Milwaukee.

Benjamin Wein, 4719 West North Avenue, Milwaukee.

G. R. Kerskey, 1714 East Capitol Drive, Milwaukee.

L. D. Taylor, 335 North 75th Street, Milwaukee.

C. J. Levinson, 723 West Mitchell Street, Milwaukee.

J. D. Hurley, Milwaukee County Hospital, Milwaukee.

D. V. Foley, 3316 West Wisconsin Avenue, Milwaukee.

D. S. Bruno, 1129 West Silver Spring Drive, Milwaukee.

Constantine Panagis, * 4300 West Burleigh Street, Milwaukee.

J. E. Callahan, * 4014 West Center Street, Milwaukee.

D. B. J. Lindorfer, 2111 North 40th Street, Milwaukee.

O. N. Arneson, Amery Clinic, Amery.

D. W. Kersting, * Marquette School of Medicine, 561 North 15th Street, Milwaukee.

R. A. Baldzikowski, Mayo Foundation, Rochester, Minnesota.

Arnold Bissegger, 80 Sheboygan Street, Fond du Lac.

A. R. Weihe, Adams.

J. F. Mokrohisky, St. Vincent's Hospital, Green Bay.

G. G. Griese, 650 South Central Avenue, Marshfield.

L. H. Stone, 133 Washington Boulevard, Oshkosh.

J. H. Koll, 80 Sheboygan Street, Fond du Lac.

D. E. Chisholm, 301 Grand Avenue, Menomonee Falls.

J. P. Schumacher, 644 Juneau Avenue, Oconomowoc.

P. A. Sciarra, 1011 North Eighth Street, Sheboygan.

E. H. Barnes, III, 520–58th Street, Kenosha.

E. L. Coles, 208 East Wisconsin Avenue, Milwaukee.

A. J. Motzel, Jr., Milwaukee County Hospital, Milwaukee.

L. L. Ruff, 8403 West Lisbon Avenue, Milwaukee.

L. H. Thompson, 650 East Green Tree Road, Fox Point.

Leo Stockland, 9320 West Lisbon Avenue, Milwaukee.

V. M. Bernhard, 7769 North Club Circle, Milwaukee.

C. W. Wolfe, 177 East Fairmount, Milwaukee.

Henry Freund, 342 North Water Street, Milwaukee.

J. R. Flanary, 3013 North 51st Street, Milwaukee.

R. R. Koenig, Columbia Hospital, Milwaukee.

T. F. McCormick, Jr., V. A. Center, Wood.

J. A. Koepke, 2200 West Kilbourn, Milwaukee.

J. T. Schulz, 2735 South Shore Drive, Milwaukee.

D. G. Burmeister, 9122 West Center, Milwaukee.

C. H. Bachman, 161 West Wisconsin Avenue, Milwaukee.

T. F. McCormick, * 324 East Wisconsin Avenue, Milwaukee.

R. G. Belatti, 120½ Bridge Street, Chippewa Falls.

Change of Address

E. M. Parkin, Oak Park, Illinois, to P. O. Box 76, River Forest, Illinois.

P. A. Dudenhoefer, San Antonio, Texas, to V. A. Hospital, Wood.

D. C. Hampel, ** San Francisco, California, to 8730 North Kildeer Court, Milwaukee.

A. W. Burek, Wausau, to 94 Center Drive, Columbia, Missouri.

R. L. MacCornack, Sr., Brandenton, Florida, to Whitehall.

G. E. Fox, Stevens Point, to St. John's Hospital, Springfield, Illinois.

R. F. Gosin, ** South Pasadena, California, to 1256 East Casad Street, West Covina, California.

L. E. Creasy, St. Petersburg, Florida, to South Wayne.

E. L. Bernhardt, West Bend, to 2107 North 48th Street, Milwaukee.

R. E. Bolinski, St. Louis, Missouri, to 4264 Beechlawn Boulevard, Columbus, Ohio.

H. C. Deering, Madison, to Metropolitan State Hospital, Norwalk, California.

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** Military Service.

NEW LICENTIATES

The following physicians were granted licenses by examination by the State Board of Medical Examiners at a meeting in Madison, January 14–16, 1958.

Name	*School of Graduation*	*Year*	*City*
Balzer, Rudolph	Zagrebacki University, Yugoslavia	1937	Evanston, Illinois
Betts, S. L.	Marquette University	1955	Fort Knox, Kentucky
Bohlman, D. C.	University of Wisconsin	1956	Madison
Burmeister, D. G.	Marquette University	1954	Milwaukee
Chen, J. Y. P.	Peking Union College, China	1941	Milwaukee
Davis, T. B.	Marquette University	1956	Iowa City, Iowa
Everson, D. M.	University of Wisconsin	1956	Pensacola, Florida
Groth, H. E., Jr.	University of Wisconsin	1955	Madison
Kelly, J. R.	University of Vermont	1956	Madison
Levin, L. A.	University of Wisconsin	1956	Topeka, Kansas
O'Brien, G. S.	University of Wisconsin	1956	Madison
Schwartz, William	Marquette University	1955	Milwaukee
Schmidt, R. A.	University of Wisconsin	1956	Milwaukee
Steiner, R. E.	Marquette University	1955	Milwaukee
Steinmetz, G. P., Jr.	University of Wisconsin	1956	Tacoma, Washington
Wilson, J. K.	Hahnemann Medical College	1956	Madison
Worsencroft, H. M.	University of Wisconsin	1956	Washington, D. C.
Zwisler, E. E.	University of Wisconsin	1953	Marshfield

The following physicians were granted licenses by reciprocity by the State Board of Medical Examiners at a meeting in Madison, January 15, 1958.

Name	*School of Graduation*	*Year*	*City*
Belza, Janusz	University of Zurich, Switzerland	1953	Carmel, California
Devine, J. C.	Oklahoma University	1953	Iowa City, Iowa
Folk, F. A.	University of Illinois	1949	Chicago, Illinois
Jansen, F. W.	University of Wisconsin	1955	New Orleans, Louisiana
Kampschmidt, William	University of North Carolina	1955	River Falls
Kerrihard, G. N.	University of Illinois	1954	Madison
Maki, H. E.	University of Michigan	1948	Milwaukee
Messer, J. W.	Johns Hopkins University	1953	Madison
Mokrohisky, J. F.	Marquette University	1948	Green Bay
Myhre, B. A.	Northwestern University	1953	Madison
Pitts, F. R., Jr.	University of Rochester	1954	Rochester, New York
Rabenn, W. B.	University of Wisconsin	1954	Madison
Reizner, Bernard	Chicago Medical School	1947	Chicago, Illinois
Sciarra, P. A.	University of Cincinnati	1951	Sheboygan
Smyth, I. P.	University College, Ireland	1948	New Haven, Connecticut
Stormont, D. L.	Rush Medical College	1929	Ephraim
Utz, P. H.	University of Michigan	1953	La Crosse
Weiss, R. C.	University of Illinois	1947	Madison
Williams, Claiborne	Vanderbilt University	1936	Milwaukee

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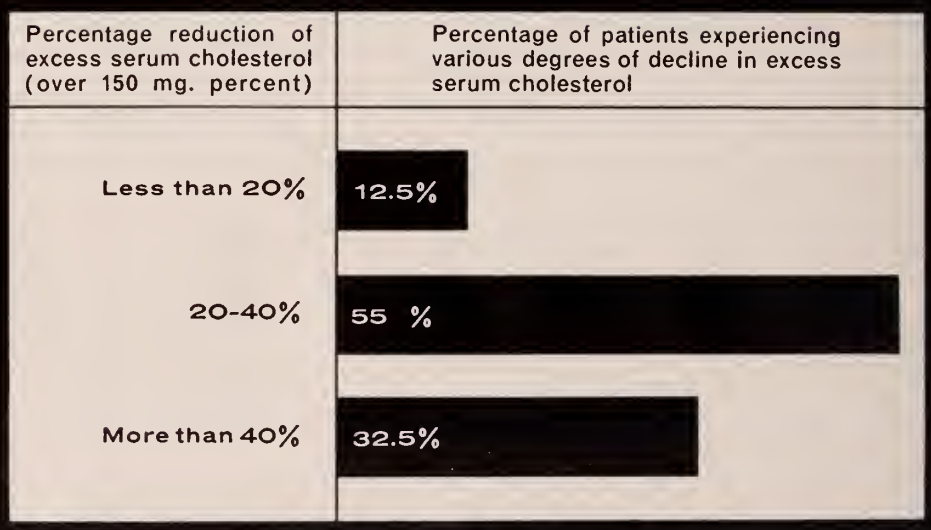

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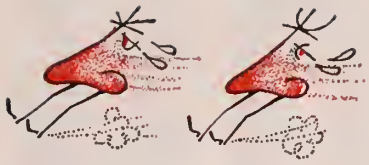
running noses . . .



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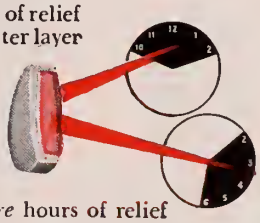

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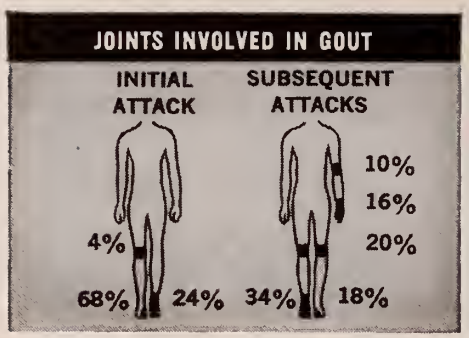

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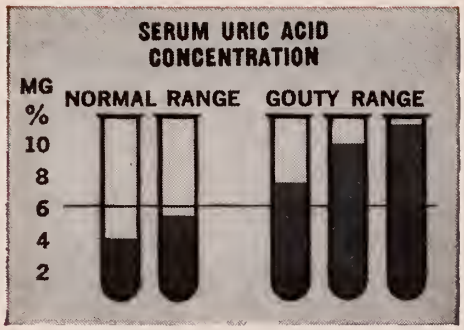

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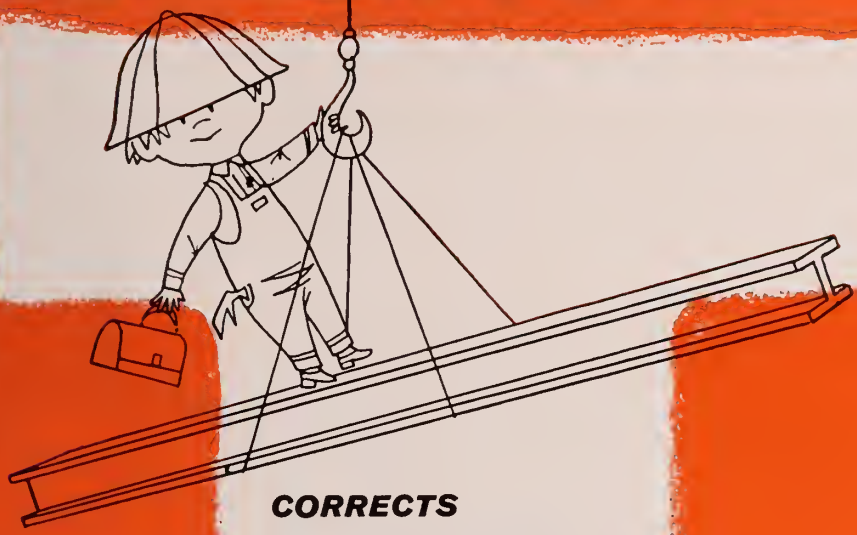

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Iron (as Ferric Pyrophosphate)	30 mg.
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Pyridoxine HCl (B_6)	5 mg.
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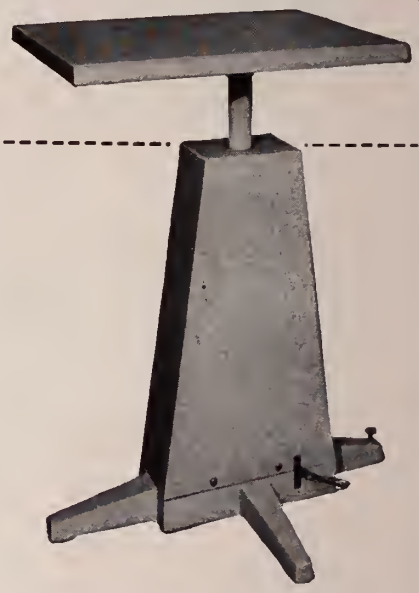

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PROGRAM, FOURTH ANNUAL MEETING
WISCONSIN STATE MEDICAL ASSISTANTS SOCIETY

Schwartz Hotel, Elkhart Lake, June 6, 7 and 8

Friday, June 6

8:00 p.m. Nominating Committee Meeting.
8:00 p.m. President's Conference.

Saturday, June 7

9:00 a.m. Registration.
9:15 to 10:00 a.m. "*This is the Place,*" by Dr. John Martineau, Elkhart Lake.
10:00 to 11:15 a.m. "*WPS and Medicare*", by Thomas J. Doran, State Medical Society, Madison.
11:15 a.m. "*Importance of Ethical Drug Firms and Their Relationship to the Medical Assistant*". by Helen Martin, Lakeside Laboratories, Inc.
1:00 p.m. Registration continues.
1:30 to 2:30 p.m. "*Public Health*", by Dr. Lloyd J. Steffen, Plymouth.
2:30 to 3:00 p.m. Movie "*Hours to Live*".
3:15 to 4:00 p.m. "*Your Public Relations*", by Oscar W. Gaarder, Madison.
6:00 to 7:00 p.m. Social Hour.
7:00 p.m. Banquet. Entertainment. Master of Ceremonies, Dr. D. E. Dorchester, Sturgeon Bay.

Sunday, June 8

9:00 a.m. Breakfast.
10:00 a.m. Business Meeting.
12:30 p.m. Luncheon. "*The Role of the Public Welfare Department in Providing Medical Care*", *by* Anthony J. Baron, Sheboygan. Master of Ceremonies, Dr. Robert J. Samp, Madison.
3:00 p.m. Executive Committee Meeting.

* **INVITED: All medical assistants in Wisconsin who are employed by members of the State Medical Society. Plan to attend!**

WISCONSIN MEDICAL ALUMNI DAY

Thursday, June 5, 1958, University of Wisconsin Medical Center

What a terrific start for a nice long weekend for you and the wife: science, old friendships, good fellowship, good speakers, reunions, the old gang, libations, good food, entertainment. WISCONSIN MEDICAL ALUMNI DAY means all this and more. JUNE 5, a Thursday, at the University of Wisconsin Medical Center.

Morning program begins at 9:30 a.m., and features:

Dr. O. O. Meyer and Dr. Karl Link collaborating on "Anticoagulants"
Dr. Joe Gale and audience on "Chest Trauma"
Dr. Ed Albright on "Recent Advances in Thyroid Therapy"
Dr. Robert Roessler, new chairman of psychiatry dept., on "Motivating Factors in Seeking Medical Help"

There will be lengthy coffee breaks, good informal luncheon, a separate luncheon and style show for the wives downtown, and a Medical Alumni Association business meeting that morning.

In the afternoon, *Dr. Conrad Elvehjem*, new University of Wisconsin president after July 1, will greet the alumni. Representative speakers from the three reunioning classes—1928, 1938 and 1948—will give short, interesting papers for the first afternoon period.

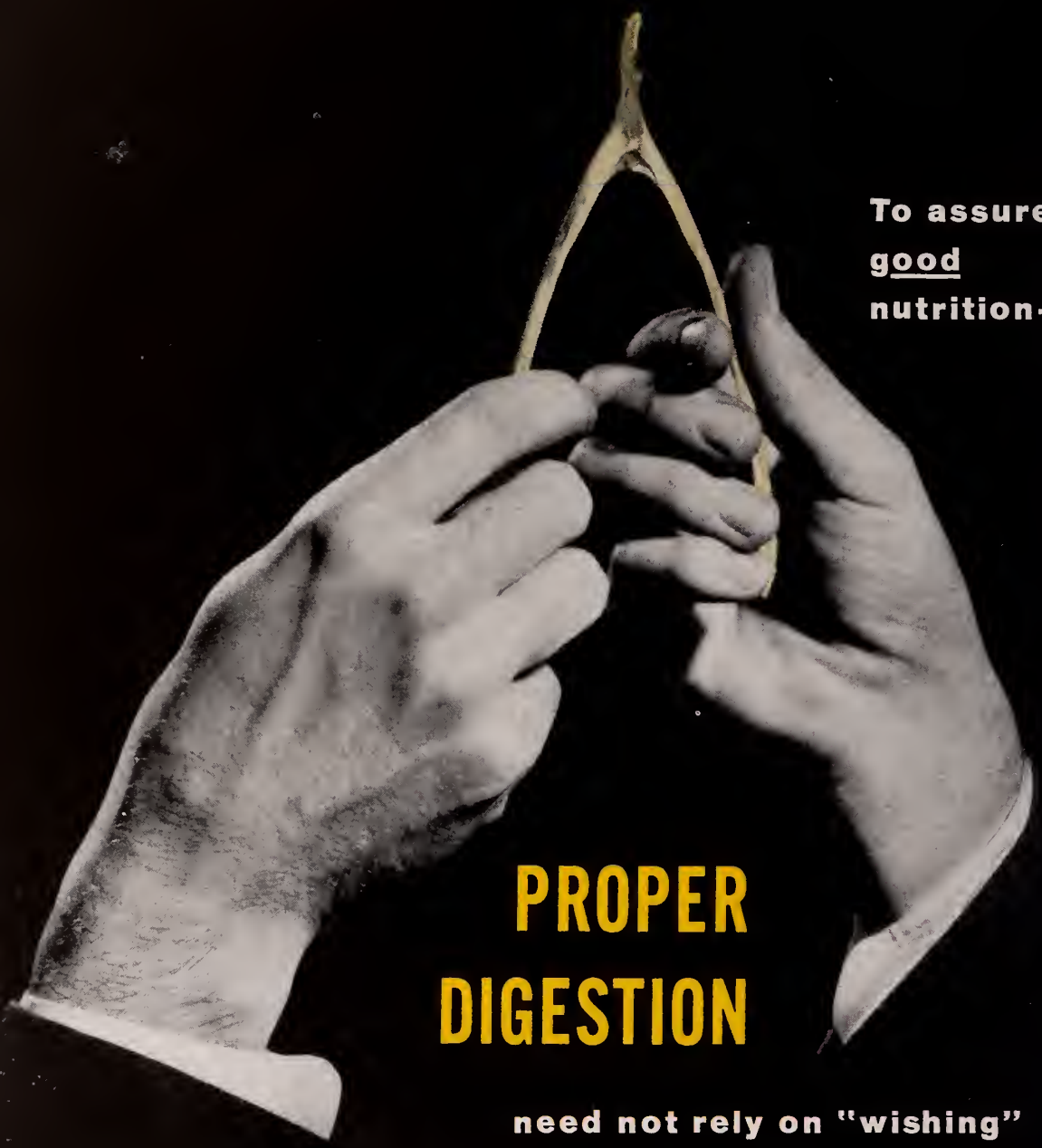
Dr. John Parks, Dean of George Washington University and Ob-Gyn man, will deliver the Dr. John Wharton Harris Memorial Lecture on "Microbes, Mid-Wivery and Modern Obstetrics."

Dr. Gunnar Gundersen, president-elect of the A.M.A., will be the featured wind-up speaker on a topic of timely concern.

The evening banquet is for wives and husbands, and honors the senior medical students graduating soon and features a private club all to ourselves—informality, Medichoir music, no lengthy filibusters, and time and a half for the interested.

Cost: All day for men—$11.00; Women: (luncheon, style show and banquet)—$7.00.

Advance registrations are required so that dinner and luncheon arrangements can be completed. Send your check (payable to The Wisconsin Medical Alumni Assoc.) to Dr. Robert C. Parkin, 418 N. Randall Ave., Madison, Wis.



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THE WISCONSIN MEDICAL JOURNAL

Volume 57 May 1958 Number 5

Instruments of Gentleness in General Surgery

By JOHN T. SULLIVAN, JR., M. D., Sc. M.*
Milwaukee

IN THIS era of radical surgery, longer operating time, more frequent infant and geriatric operative procedures, and the use of antibiotics, the causes and effects of surgical trauma are sometimes forgotten. The preoccupation with and objective of the procedure at hand may quite easily cause the operator to lose track of the nature and physiologic results of such trauma. Although surgeons trained in basic surgical principles are quite familiar with this aspect of surgery, habit and familiarity with a procedure can cause the omission of surgical gentleness. Likewise, this can occur among surgical residents who might feel somewhat imposed upon when required to perform what they may consider menial surgery. With this thought in mind, discussion of the following instruments and their proper use will aid in stressing the ever-important principles of surgical gentleness and avoidance of tissue trauma.

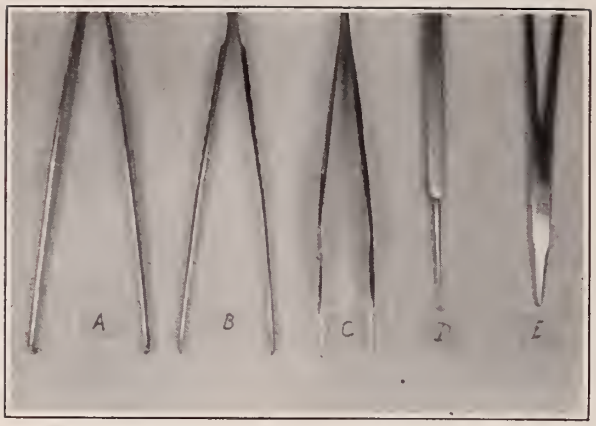
Tissue trauma of any degree calls forth a corresponding physiologic response in ratio to the severity and extensiveness of the trauma. With minor localized trauma this response may be nil when considering the general clinical status of the patient; nevertheless, it exists at the site of surgery. Even in a small localized area, if the surgical trauma is severe enough, there will be delayed healing, increased discomfort, and possibility of complications.

Of greater importance is a situation where tissue trauma, although relatively minor when existing as a single isolated entity, is widespread and involves delicate viscera and areas already prone to complications. The clinical manifestations of the surgical trauma (omitting for the present the nature of the surgery performed) can be considered the sum total of all the small separate tissue traumas inflicted during the operation, plus the resulting physiologic response. These individual minor tissue insults are known to contribute appreciably to operative complications, morbidity, and even mortality, especially when present in the very young, the elderly, or debilitated patient. Because the physiologic reserve of any given patient cannot always be accurately anticipated, the basic surgical precept of maximum tissue gentleness should be mandatory.

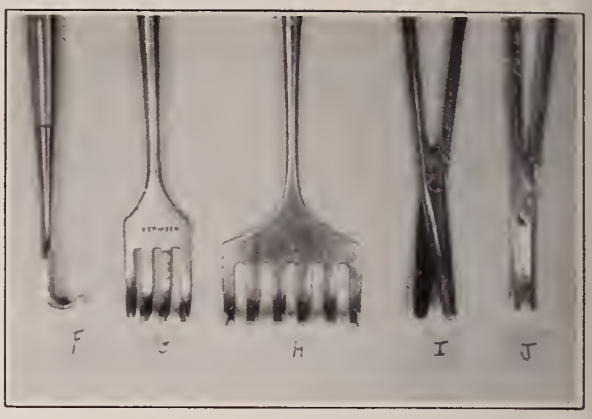
Surgical gentleness, because of its rather minor role as compared to that of specific established surgical techniques, must exist as a subconscious habit in order to be effective. Frequently a complicated operative situation leaves little thought at the time for the effects of tissue trauma. Although the use of some of the following or similar instruments may aid in a "gentle touch," it is actually the attitude and degree of respect of the operator for "tissues" which determine the effectiveness of his technique. Following a "chain of command," it is logical to expect that the assistants will exercise the same degree of "gentleness." Within the realm of retraction lies many "tissue insults," and with proper and repeated instruction of assistants by the operator, habits are initiated which will become readily "fixed."

Tissue trauma in a surgical procedure starts with the skin incision. Multiple false, parallel, and ragged incisions are prone to delayed healing and poor cosmetic appearance. Further "insult" is added when skin edges are roughly grasped with heavy multitoothed tissue forceps (fig. 1a) or crushed with tissue forceps without teeth (fig. 1b),

* Assistant Clinical Professor, Department of Surgery, Marquette University School of Medicine.



(Figure 1)



(Figure 2)

the latter frequently slipping in their grasp. It is for this reason that fine single-toothed dural tissue forceps (fig. 1c) and fine dural hooks are best utilized in handling skin edges in areas of cosmetic significance such as the face, neck, or hand or when dealing with vascular or tendon repairs. Such "cosmetic trauma" occurs to a greater degree during the skin closure.

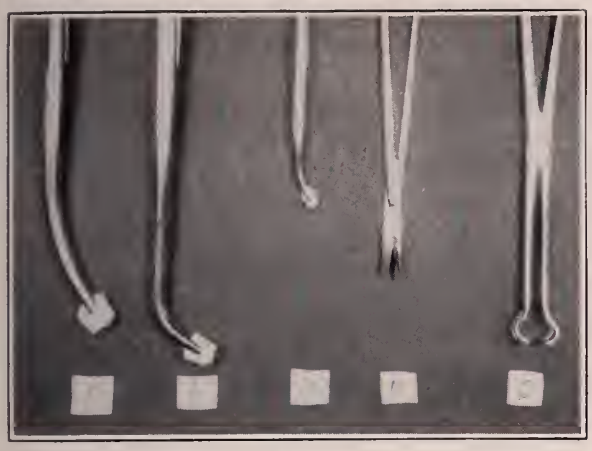
Probably the greatest nidus for incisional wound infection occurs in the fatty subcutaneous layer, usually proportionate to its thickness. It is here that numerous small bleeders are encountered following incision. Many such bleeders can be controlled with pressure alone but when large "bites" of fatty tissue and ligation with heavy ligatures take place, the necrosis factor is increased. Thus, existing bacteria are provided "extra rations." Fine-pointed Halsted or mosquito hemostats (fig. 1e), properly applied to the bleeding points, and ligation with a fine ligature which is cut "on the knot," will reduce tissue destruction to a minimum.

Also in the subcutaneous fatty layer, considerable trauma may result from the use of smooth blunt reactors. The fat content provides an excellent lubricant for slippage of such instruments. This may be markedly reduced by utilizing sharp "cat's paw" rake retractors (fig. 2 f, g, h) which, after being correctly positioned, will remain so until removed. These instruments, even in small incisions, provide for less trauma except perhaps to the operator's or assistants' degits. When used in abdominal surgery they are replaced by deeper blunt retractors upon entering the peritoneal cavity, for obvious reasons.

Although adequate exposure of the operative field cannot be considered an instrument *per se*, nevertheless it may play an important role in providing for surgical gentleness. It would appear to be a dubious surgical accomplishment to perform vital major surgery through a small, inadequate incision. Certainly tissue trauma is increased, aside from the hazards of damage to vital anatomical structures.

As many skilled operators will testify, the use of Metzenbaum scissors (fig. 2i, j) in various lengths has facilitated blunt dissection as well as reducing damage to important structures. Often their use as "refined and gentle" dissectors has exceeded their function as "scissors." Because of their delicate thin construction, they respond more readily to a "light touch" than heavy curved dissecting scissors.

A further aid when gentle, delicate blunt dissection is required, such as adjacent to important blood vessels, the common duct and neck structures, is the use of small rolled gauze or umbilical tape dissectors at the end of a curved hemostat (fig. 3 k). Such a dissector can provide maximum gentleness for structures close to the skin surface which are large in caliber, as an inguinal hernia sac or the sapheno-femoral junction. Deeper structures such as the cystic and common ducts, require a longer instrument with a somewhat greater curve. A long right-angle Mixter gallbladder forceps (fig. 3 l) permits the operator a better view of the tip of his dissector. Infant surgery and some forms of extremely delicate dissection call for very fine instruments such as a small curved mosquito



(Figure 3)

hemostat with a gauze dissector the size of a match-head (fig. 3 m). Its use in cut-downs about the sapheno-femoral area in the newborn is essential.

Likewise, an iris eye scissors (fig. 3 n) for fine sharp dissection can be of great help in infant cut-downs and hand surgery. In both these procedures small sharp rakes (fig. 2 f) and sharp dural hooks (fig. 1d) find ideal use.

Retraction of cordlike structures such as the spermatic cord, tendon groups in the wrist or forearm, and ureters may be performed efficiently and without undue trauma by looping a narrow moistened Penrose drain about them. The use of an open, dry gauze sponge as a substitute for the Penrose drain is far from ideal because increased friction during movements of the dry rough gauze will produce an unnecessary amount of tissue trauma. Warm (never hot or cold) normal saline solution for all packs and sponges coming into contact with serous surfaces (*e.g.*, peritoneum) is a basic precept. When sterile water (hypotonic) is erroneously used, it can, when added to numerous other minute traumas, result in hastening surgical shock and adverse physiologic responses. This is likewise true when solutions are too hot or too cold.

Tradition alone should have no place in selecting surgical instruments for a given operation. The utter acceptance of a hospital's "routine instrument setup" for a given procedure leaves the selection and choice of instruments up to the surgical nursing staff; they, in turn, usually fall back on "traditional lists," often prepared by "long forgotten" surgical supervisors of years past. Operators should be well trained in and quite familiar with all instruments required in a surgical procedure. Such a surgeon will never be dependent on the "whim" or choice of his instrument nurse regarding "which instrument comes next." Frequently there is great advantage gained in "borrowing" specific instruments used in one surgical field and applying their use to a totally different and unrelated operative procedure. It is thus possible for an individual surgeon to keep constantly improving his technique long after his formal training has been completed. It is probably this desire for improvement and a certain "mechanical curiosity" which accounts for the wide selection of instruments available on the market today.

There are many more instruments and techniques than mentioned above which provide for lessening of operative tissue trauma. Modern surgical concepts show acceptance of the necessity and importance of operative gentleness so stressed by Halsted. The days of "roughshod," hurried "traumatic" surgery are well on the wane. They belong to a historical vintage best kept in the dusty tomes of our surgical past.

SUMMARY

1. Accumulation of minute tissue traumas and their physiologic response during any operative procedure contribute to surgical complication, morbidity, and even mortality, especially when existing in very young, elderly, or debilitated patients.

2. Reduction of operative trauma results from surgical gentleness on the part of the operator and his assistants. It must stem from the operator's attitude and degree of respect for tissue and is most efficient when the result of a "fixed habit."

3. Examples of "instruments of gentleness" and their use are outlined.

4. Surgeons should constantly strive to improve their individual "gentle touch" technique.

5. The era of "roughshod," hurried, "traumatic" surgery belongs in the tomes of the surgical past.

2040 West Wisconsin Avenue.

Treatment of Depressive States in a General Hospital

By JOSEPH E. WEBER, M. D., F. A. P. A.
Milwaukee

IN DEALING with depressive states, the reactive depression must be differentiated from the psychotic depression. The former is the neurotic depression which follows some more or less conscious conflicts relating to the death of a loved object, loss of income, chronic illness, or some other severe situational stress. In the psychotic depression, the precipitating factor is usually minimal. The depression occurs spontaneously, probably on the basis of unconscious conflict or cerebral dysfunction, and tends to recur periodically. Family history is frequently positive. In both the reactive and endogenous depressive states, insight is relatively preserved and the ego, although disturbed, seeks restoration and recovery.

Treatment of choice for the reactive endogenous depressions must be aimed at understanding the situation and resolving the conflict. In this group, psychotherapy is the treatment indicated. The concepts or dynamic factors introduced by Freud and Abraham[1] relating to dependency and hostility are of value. In the psychotic depressions, however, psychotherapy is usually contraindicated. A positive relationship between therapist and patient becomes difficult if not impossible. Free association usually leads to verbalization which confirms the irreversibility of the patient's condition. In such cases immediate hospitalization and convulsive therapy should be advised.

As life expectancy increases, psychotic depressions will probably occur with greater frequency. There will be more involutional melancholias and senile depressive states. Up to about twenty years ago, prior to the discovery of convulsive treatment by Cerletti, these patients were all referred to either private or state institutions for treatment. In many cases, the depression became chronic and continued for many years; in others the depression lifted spontaneously after more or less extended periods. During the past two decades, however, many of these patients have been treated in general hospitals and have been restored back to health and usefulness in short periods of time. Silvano Arieti[2] has compiled statistics on admissions to New York State Hospitals which reveal that, in 1928, 10% of patients were admitted with depressions while in 1948 only 3.8% had depressions. These figures would tend to show that many patients were adequately treated by private psychiatrists in general hospitals or as out-patients.

The endogenous depressions are characterized by retardation and agitation. The patient reveals slowing of reaction time and becomes more compulsive and accurate in performance. His interests are constricted and his imagination narrowed and rigid. Doubts, fears, and repetitive stereotyped behavior keeps the patient and his family in constant distress. The history obtained reveals difficulty in sleeping, eating, and working. Every movement appears forced and every decision difficult. As the anxiety increases, the patient begins to look for escape in self-mutilation or self-destruction. Hoch[3] describes depressions as follows, "The patient surrenders his defenses, his ego becomes paralyzed and he looks forward to nothing but annihilation."

Milder cases, or those less far advanced, usually seek help but generally respond poorly to either sedative or stimulating drugs. Much suffering would be avoided if the diagnosis could be established during this stage and convulsive treatment started. The patient and his family usually regard the illness as emergent and will accept whatever treatment is indicated.

Kalinowsky[4] has described a group of depressive patients whose psychosis is masked by neurotic symptoms, some resembling psychoneurosis and some the personality disorders. He refers to these as pseudoneurotic depressions. This group's symptoms are characterized by various fears and phobias, vague somatic complaints, and irritability and disturbed behavior of various kinds, including alcoholism. After repeated episodes of anxiety, it becomes clear that the patient is in a depressive state. In other words the psy-

chosis masquerades behind neurotic manifestations until these defenses gradually give way.

Donald W. Hastings[5] points this out in several of his patients who revealed repetitive and chronic pains, who had been operated upon many times, and whose psychological structure was essentially the same as depressed persons; that is, they were unable to handle even normal aggressive feelings and had a tremendous accumulation of guilt feelings. Electric shock frequently relieved these people of pain for a more or less extended period.

Depressions of varying intensities are common among the aging population and sometimes occur along with organic illnesses such as cardiac disease or degenerative diseases. Involutional melancholia may occur in women from the age of 40 to 50 and in men from 50 on. Self-destructive, suicidal urges occur frequently. The patient sometimes complains of precardial distress, tachycardia, elevated blood pressure, and feelings of difficulty in breathing or in digestion.

Schizophrenia, senile dementia and organic brain disease must each be differentiated from depressive states. In schizophrenia, recovery by therapeutic measures is not the aim of the patient. Insight is lacking and delusional and hallucinatory states are usually evident. Depression in a schizophrenic may occur in response to his false ideas or his unreal perceptions, or it may mask the picture. These patients are relatively refractory to electroconvulsive therapy and require 20 to 30 treatments along with insulin coma. Unless physical security measures are available such as locked wards, restraints, and adequate nursing care to tranquilize these patients, they are better off treated in regularly established mental institutions.

THE ORGANIC GROUP CONSISTS LARGELY OF SENILE DEMENTIA AND BRAIN TUMOR

In senile dementia, childish deteriorated behavior, with defects of memory and awareness, is characteristic. There is often paranoid reactions and grandiose ideation. This condition appears to be largely irreversible and is usually refractory to treatment.

In brain tumors the diagnosis is made by the discovery of focal signs, lethargy and facetiousness. It is, of course, essential that a careful neurological examination be done on all patients with depressions.

During the past 18 months, 25 depressed patients were admitted to the medical service of a small 38-bed, general hospital. No special section of the hospital was set aside and no specialized nursing care was available. The patient was accepted only if he and his family were willing to accept responsibility and to cooperate. The treatment was explained in detail to both the patient and to his nearest relative. They were informed that if complications arose and further hospitalization was required, transfer to a mental hospital would be advised.

ANALYSIS AND EVALUATION OF TREATMENT

In this group, the longest period of hospitalization was 21 days and the shortest seven days. The youngest patient was 20, and the oldest 76. There were 10 men and 15 women treated. Seven were schizophrenics with depression which covered delusional and hallucinatory states. All of these after from four to eight treatments had to be transferred to various mental hospitals for further treatment. Four were psychoneurotics who responded quickly to psychotherapy and mild sedation. The remaining 14 patients were in typical depressive states either of the manic-depressive, depressed type, or involutional depressions. All of this group responded to treatment. Five of these returned within a month or two for another series, and several had to receive a third series subsequently.

Each patient received a thorough physical and neurological work-up, including electrocardiogram, blood and urine studies, and x-ray of the chest. There were two patients with hypertension and myocardial damage who were treated with convulsive therapy with good results. In one patient, a lymphatic leukemia was accidentally discovered. He responded to four treatments and was referred to a hematologist for follow up and treatment. Gallstones were discovered in two women. Following treatment, they were both referred for surgical consultation.

In most cases a marked improvement in mood and adaptability occurred after the second or third treatment. Another three or four convulsive treatments were usually given to re-enforce the progress and to insure stability. Most recovered patients refused to stay longer than 2 or 3 days following their last treatment. Severe post-shock confusion sometimes occurred when treat-

ment was given daily. In those who received the standard three treatments weekly, no significant confusion occurred.

Intravenous barbiturates were carefully avoided. These were felt to increase the risk. However, succinylcholine chloride (B. W. & Co.) in 10 to 15 mg. dosage was given intravenously immediately prior to treatment in each case to provide muscle relaxation and to avoid too violent convulsions. One tablet of meprobamate (Wallace, Wyeth) 400 mg. and atropine sulfate 0.6 mg., intramuscularly, were routinely ordered one-half hour prior to treatment. Following the convulsion, a few whiffs of oxygen were administered and the patient was placed in restraints for about 30 minutes to prevent his falling out of bed or annoying others during his post-shock confused state. This technique, especially the use of succinylcholine chloride, has entirely eliminated the danger of fractures.

The mode of action of electroconvulsive therapy has been the source of much speculation. It is believed by some that the fear of treatment is the basis for improvement. Others have suggested that electroconvulsive therapy satisfies a need for punishment stemming from feelings of guilt, or that the fear of death provoked by the treatment or the victory over a death threat with symbolic rebirth, is responsible. A large number of investigators, particularly those who actually administer this treatment, have emphasized the direct effect of the electric current introduced into the brain. This has been variously described as stimulating, disrupting, or damaging to specific or diffuse areas of the brain. Neither of these theories, the psychological or the organic, has as yet been proven. All we can say now is that this treatment has helped restore many depressed patients back to health. This success cannot be claimed by the new and remarkable tranquilizing drugs. As a matter of fact, they are usually of little value in the depressive reactions. This does not mean, however, that tranquilizers are of no value in psychotic states. I believe that there are many indications for these drugs.

In summary, I have presented some aspects of the diagnosis and management of depressed patients treated in an open ward of a small general hospital. It is my opinion that the cooperative depressed or melancholic patient can be treated adequately in a general hospital. Admission to a mental hospital should be advised only after every attempt has been made to help the patient privately with the use of drugs, psychotherapy, and electroshock.

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POSTGRADUATE COURSE IN OCCUPATIONAL MEDICINE
SEPTEMBER 15 THROUGH NOVEMBER 7, 1958

The New York University Post-Graduate Medical School, Institute of Industrial Medicine, is sponsoring a two-month course in occupational medicine starting September 15 and continuing through November 7. The course is designed for physicians engaged in the practice of medicine in industry, full-time or part-time. The program is being offered in recognition of the need for specialized training in industrial medicine.

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Stapes Mobilization for Otosclerotic Deafness

An Analysis of 152 Cases

By GERHARD D. STRAUS, M. D.*

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FOR well over one hundred years otologists have been aware of the connection between certain types of deafness and ankylosis of the stapes footplate. In the years from 1876 to 1902 attempts were made by Kessel[1], Boucheron[2], Miot[3], Blake[4], Jack[5], and others to improve hearing by removal of the stapes, severing of the stapedius tendon, or mobilzation of the stapes via a myringotomy incision. It was noted that while removal of the stapes might improve hearing for a few days, the improvement soon disappeared to be followed frequently by additional hearing loss. Mobilization of the stapes seemed to give some early good results. By the turn of the century, however, most otologists had come to the conclusion that stapes mobilization and stapes removal were not desirable procedures. Whether this was based on difficulties in technique, poor initial results, or rapid recurrence of deafness in the early successful cases is not clearly understood at this time and these procedures were generally dropped.

In 1911 Barany conceived the idea that producing an opening in the labyrinthine vestibule might improve hearing. For the next thirty years various surgeons worked at this problem. Operations opening the horizontal semicircular canal resulted in improvement of hearing only to be followed by a loss in a matter of days or months. The monumental work of Holmgren and Sourdille led to the practical, one-stage fenestration operation of Lempert[6] in 1938. Since then many refinements and improvements in technique have brought this surgery to the point where patients with otosclerotic deafness and good auditory nerve function have between an 80% and a 90% chance of restoration of hearing to a useful level, with only a very small chance of morbidity. Hearing is restored in these people by short circuiting the sound around the fixed ossicular chain through the surgically created new oval window in the vestibule, so that airborne sound moves the cochlear perilymph. The disadvantages of this operation are the extensiveness of the surgery, the postoperative disability of the patient (usually about three weeks), and the frequently prolonged postoperative management.

In 1952, using incisions developed by Lempert for middle ear surgery, Rosen[7] was exploring a patient's middle ear and probing the stapes to test for fixation when he noted that the stapes suddenly became loose and the patient began to hear well. Later, with other patients, he made deliberate attempts with specially devised instruments to free the stapes by pressure on the stapedial neck. He subsequently reported his results indicating a significant number of successes. This procedure was almost immediately tried by otologists here and abroad using various techniques of mobilization and with gradually increasing success.

PATHOLOGY AND PATHOGENESIS

The disease consists of foci of vascular spongy bone in the labyrinthine capsule with the site of predilection being immediately anterior to the stapes footplate. There is invasion of this new bone into the annular ligament of the stapes and then into the footplate itself, thus bringing about a gradual ankylosis of the footplate with a gradual, progressive loss of hearing. The etiology of this disease is unknown. Some believe that the otosclerotic bone grows from a minute embryonic cartilage rest anterior to the stapes footplate in the fissula ante-fenestrum. Other investigators have studied its relationship with endocrine imbalance and calcium and phosphorus metabolism with no real connection being established. In many cases there is added acoustic nerve degeneration, the cause of which is also unknown.

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There is a distinct familial tendency in this disease and females are afflicted twice as frequently as males. The usual onset of deafness is in teen age or early adulthood. Otosclerosis is the most common cause of progressive conductive deafness, and based on the work of Nager and Guild it appears that about 1% of the population may be suffering some hearing loss from it.

DIAGNOSIS

The diagnosis of otosclerosis is established fundamentally by hearing testing. Given a history of long standing, progressive conductive hearing loss, with a relatively normal tympanic membrane and patent eustachian tubes, a diagnosis of clinical otosclerosis can be made. Conductive hearing loss can be determined by air and bone conduction audiometric and tuning fork tests. When the bone conduction of sound is better than the air conduction, the patient is suffering from a defect in the transmission of airborne sound to the cochlea, in other words, a conductive deafness. Tinnitus is frequently present, as is an apparent improvement of hearing in noisy places.

Because the frequently associated nerve deafness lowers the bone conduction audiogram, a prediction can be made of the probable postoperative hearing level by studying these audiograms, since the level of hearing in successful cases is frequently related to the bone conduction level.

TECHNIQUE

The techniques used in this series are fundamentally derived from those used by Rosen, Goodhill, Kos, and others. Antibiotics are administered preoperatively and for several days postoperatively. One hour preoperatively pentobarbital sodium (Abbott) 100 mg. and meperidine hydrochloride (Breon, Winthrop), 25 mg., are administered, causing mild sedation. Heavy sedation is undesirable since it interferes with the operative audiometry, and drowsiness can result in involuntary sudden movements of the head. The hair is flattened back with sterile vaseline and the ear and surrounding area are prepared by thorough washing with soap and water. Aqueous benzalkonium chloride (Winthrop), is then applied, some being used to fill the ear canal. The field is draped in such a way that only the ear protrudes.

One cubic centimeter of a mixture of three parts of 2% lidocaine hydrochloride (Astra) and one part of 1:1,000 epinephrine (Parke-Davis) is injected into the skin of the superior, posterior, and inferior external auditory canal wall. A Zeiss operating loupe with two and one-half power magnification and a Lempert headlight are worn at this stage. The operation is performed through an ear speculum. Using a right angled knife, an incision is made from 12 o'clock to 6 o'clock in the skin of the posterior portion of the external auditory canal wall 5 to 7 mm. external to the tympanic membrane. From the ends of this incision further incisions are made medially to the annulus, forming a shallow U-shaped incision. The skin and periosteum are separated from the bone medially to the annulus tympanicus and the posterior half of the tympanic membrane is lifted from its sulcus and reflected anteriorly. In some cases this exposure brings the operative field into clear view; in most instances, however, it is necessary to remove 1 to 3 mm. of bone from the posterosuperior rim of the bony annulus. Often it is necessary to reflect the chorda tympanic nerve downward and occasionally to sever it.

The tympanic membrane is then replaced into its normal position closing the tympanic cavity. An audiogram is then made. This serves as the base line from which further studies are made after manipulation. The tympanic membrane is again reflected anteriorly and another audiogram is made. The Zeiss operating microscope is then brought into the field and the remainder of the procedure is performed under 10x or 16x magnification. One can clearly see the long crus of the incus, the incudostapedial joint, the stapedius tendon, the round window niche, the promontory of the middle ear and frequently the crura of the stapes, a portion of the stapes footplate, and the canal of the facial nerve. Occasionally adhesive bands are seen binding the various middle ear structures; these are severed when present.

The head of the stapes or the lenticular process of the incus is then engaged with a needle probe and the mobility of the stapes is tested. All of the stapes in this report were found to be firmly fixed. Using a fine rocking motion in an anterior-posterior direction as well as inferior-superior direction with the microscope focused on the stapes footplate and crura, the stapes is gently but firmly rocked until movement of the footplate is elicited. If this cannot be achieved, attention

is directed to the margins of the footplate and scraping, poking, and prying movements are attempted here with a needle probe to weaken the ankylosis. Pressure is again exerted against the head of the stapes. If the stapes becomes loose the patient will usually notice great improvement in hearing and audiometric testing will show considerable improvement. Frequently when the stapes is rocked, counter movement can be seen in the round window niche. If the stapes has been mobilized or if the disease is so far advanced as to preclude mobilization, the skin and tympanic membrane are replaced and an audiogram is taken. A small piece of flattened gelfoam is placed over the incision and a mastoid bandage is applied. A small number of patients have vertigo for a few hours postoperatively. The bandage is removed the next morning and a piece of sterile cotton is placed in the canal and the patient is dismissed from the hospital. He may return to work the next day and returns to the doctor's office in one week. If clot is present, it is removed and an audiometric test is done. A visit two to three weeks later completes the immediate postoperative management. The patient returns in six months, in one year, and yearly thereafter for hearing tests.

RESULTS

One hundred fifty-two operations have been performed from January, 1956, to September, 1957, and have been followed from one to twenty months. There have been 82 immediately successful cases, or 54%. Success was determined by restoration of hearing to the serviceable level of an average of 30 decibels of loss or less in the conversational range of 500, 1,000, and 2,000 cycles, or by achieving hearing within 10 decibels of the bone conduction level where the bone conduction curve precluded improvement to a serviceable level. The later group achieved 20 decibels or more improvement. Those patients whose bone conduction curve indicated a possibility of achieving serviceability but did not do so are not included, even though some had considerable improvement.

There has been loss of the early improvement in hearing in 4 cases. Of these 4 cases, one revision has been performed and serviceable hearing was achieved. One revision was performed on a previous failure with successful mobilization and restoration of good hearing.

Four fenestrations have been performed on unsuccessful cases with no additional technical difficulty.

COMPLICATIONS

Four patients have had vertigo lasting for two to four days with no loss of the operative gain. There was one case of external otitis which responded easily to treatment. Some patients have had a loss of taste sensation of half of the tongue on the operated side. This usually returns in a few months.

Two of the unsuccessful cases had 10 decibels additional loss of hearing but in neither of these cases did it add to the already existing practical disability.

There were no cases of facial paralysis, permanent perforation of the tympanic membrane, or loss of hearing from labyrinthitis. There was no otitis media.

COMMENT

The stapes mobilization procedure presents the following advantages. It restores the normal transmission mechanism of sound to the internal ear; and since the period of disability is small, usually only three days including the two days of hospitalization, it is a relatively minor procedure for the patient. If this operation is a failure the fenestration operation can be performed in the same ear four to six months later. It is adaptable to many people with associated nerve deafness for whom the more extensive fenestration is undesirable because of the predicted limited gain. A mobilization procedure may, however, be of considerable service to them even if the hearing is not completely serviceable. It is very useful in people with unilateral deafness for whom the risk and disability of fenestration is not desirable and is particularly applicable in the second ear of people who have had a successful fenestration.

The disadvantages of this surgery at the present time lie in the lesser chance of success as compared to fenestration, in the unpredictability of the immediate outcome of the surgery, and of course the unpredictability of the duration of success. The latter point, of course, will be solved by the passage of time. Rosen now has cases that continue to retain hearing five years postoperatively; in my series some have continued to have good hearing for eighteen months.

Most otologists now believe that those patients whose preoperative study indicates suitability for either stapes mobilization or

fenestration should be presented a surgical program for rehabilitation of hearing in which stapes mobilization is tried first to be followed by a fenestration if unsuccessful. Of course, in those patients whose bone conduction curve is too low to warrant fenestration, only a stapes mobilization can be done.

SUMMARY

One hundred fifty-two consecutive cases of stapes mobilization for restoration of hearing in clinical otosclerosis have been reported. Of these, 82, or 54%, have achieved immediate success in terms of either restoration of hearing to a serviceable level or substantial improvement in those patients whose nerve function precluded reaching this level. To date there have been 4 cases of stapes reankylosis. One revision has been done on these cases and the patient achieved serviceable hearing.

The stapes mobilization is now an established procedure in the armamentarium of the otological surgeon; however, the evaluation of long term results awaits the passage of time.

Addendum: Since submitting this paper for publication in October, 1957, I have changed my technique to a direct approach to the stapes footplate. Minute chisels are used to cut through the otosclerotic foci and thus free the stapes footplate in the oval window. In 75% of the cases the stapes footplate was mobilized. Thus, early results indicate a much higher percentage of immediate successes than by the technique outlined in the body of this paper.

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Obstetrical Brief

From the Study Committee of the Maternal Mortality Survey
Division on Maternal and Child Welfare, State Medical Society of Wisconsin

Magnesium Sulfate in Obstetrical Care

Magnesium sulfate *in adequate dosage* is an excellent drug in the management of severe pre-eclamptic and eclamptic toxemias particularly where convulsions are imminent. All too often the homeopathic, totally ineffective, intramuscular doses of 2 or 3 grams (4 to 6 cc of 50% solution) are used in an attempt to control the convulsive manifestations of this disease. To obtain any useful nervous system depression, an initial dose of 8 to 10 grams is necessary and safe in the 50 to 70 kg. female. The drug should be given deep intramuscularly, no more than 2.5 grams (5 cc of 50% solution) in any one site, to reduce local reaction. The blood levels obtained will reach their peak in approximately two hours returning to ineffecive levels in approximately four hours. A maintenance dose of 4 to 6 grams should be given every 4 to 6 hours as necessary, but only after the knee jerks are demonstrated. Their absence indicates that toxic levels are present and contraindicates additional drug until they reappear. Loss of the ability to expand the chest on deep respiration indicates serious toxicity and requires the administration of calcium gluconate, 1 gram or more intravenously (10 cc of 10%), an antidote which should always be available. When used in this manner, in conjunction with appropriate hypotensive therapy, intramuscular magnesium sulfate is a safe and useful adjunct to therapy for the toxemias of pregnancy.—

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Recent Developments in Antibiotic Treatment*

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ANTIBACTERIAL agents have been used for a sufficient time so that most of the fundamentals concerned in their use have been well documented. There is little doubt that the therapeutic triumphs with these agents have changed the entire practice of medicine. This has been most noticeable in the field of pediatrics but has had an effect on every branch and facet. It is useless to recount the long list of conditions in which the drugs are indicated and are essentially uniformly effective. In addition, there are the many operative procedures made possible by the mitigation of complicating infections, many chronic infections which can be suppressed, and a few situations in which prophylaxis is successful. However, it has also been apparent that the rapid conquest of one condition after another has slowed. New methods of dealing with the old and some new problems have been developed but much less dramatically than during the first 10 years after the discovery of penicillin. In this paper a brief review of the progress during the last five years will be made.

The problems to be considered fall logically into the following categories:

1. Those concerned with infections caused by organisms which have been refractory to treatment.
2. Infections complicating other diseases often chronic.
3. Problems of diagnosis and application of therapy in the most efficacious manner.

In order to recount what has been accomplished toward understanding these problems, it is necessary to consider five major topics in which progress has been made:

1. The discovery of new agents.
2. The origin of antibiotic-resistant organisms.
3. The incidence and nature of superinfections.
4. The advantages and disadvantages of drug combinations.
5. The prophylactic use of antimicrobial drugs.

In retrospect it seems likely that the rate of discovery of successful agents with new modes of action has slackened. Following the introduction of chloramphenicol (Parke-Davis), the tetracyclines (Lederle), erythromycin (Abbott), and isoniazid (Pfizer) in rapid succession, there has been a succession of agents studied which have either been shown to be closely related to the previously described antibiotics, or have had limited use because of toxicity or difficulties in administration. Progress has been made, however, in perfecting formulations of the older drugs that make administration simpler and absorption more complete. Moreover, some of the newer analogues have improved pharmacologic properties and there have, in addition, been described several new agents which are successful in a limited number of conditions which were not previously treated as well. Among the agents that have been introduced which are analogues of one of the major drugs are penicillin V (Lilly, Wyeth, Abbott), oleandomycin (Pfizer), and sulfamethoxypyridazine (Lederle). Other agents such as synnematin, a penicillin-like agent, and spiramycin in the erythromycin family have not been made available. The former agent is quite effective against Salmonella infections but has not been economically feasible and the latter, which has had considerable success in Europe, has little to recommend it since erythromycin and oleandomycin have better pharmacologic properties and approximately the same antibacterial activity. Similarly, there was little reason for the introduction of oleandomycin. While it is true that there is not an absolute correlation between the minimal inhibitory concentration of erythromycin and oleandomycin for all strains, particularly those of the Staphy-

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lococcus, there is sufficient similarity of action that the use of one drug will frequently lead to the appearance of strains resistant to the other. On the other hand, among the sensitive strains erythromycin is several times more effective on a weight basis than oleandomycin and the blood levels obtained with a given dose are equally high or higher. At the present time it would seem that erythromycin is the most effective of this group, oleandomycin and spiramycin next, and carbomycin the least. The last-named drug has given such uniformly poor results regardless of *in vitro* sensitivity results that it is best omitted. In spite of *in vitro* sensitivity differences, successful treatment of an erythromycin-resistant Staphylococcus with one of the other agents has been rare. Most frequently the organism rapidly becomes resistant to the second analogue.

Penicillin V, on the other hand, has activity almost identical with penicillin G but is absorbed better when given by mouth. This drug may be used in somewhat lower doses with equal reliability.

Sulfamethoxypyridazine has the usual sulfonamide antibacterial action but has the favorable property of maintaining high serum and tissue concentrations for a prolonged period after a single dose. Thus, following a 30 mg. per kilogram dose the drug is still demonstrable in the serum one week later. It is possible, therefore, to find very convenient dose schedules for any purpose.

NEW DRUGS RESTRICTED

Many drugs in new families have been introduced but each has been restricted in its usefulness. Novobiocin (Upjohn) promised to be a useful drug in that it was well absorbed and the serum concentrations obtained were quite high. Moreover, most cocci, many Gram-positive rods, and a few Gram-negative rods were quite sensitive to its action. However, as the drug was tested it was shown to cause a high incidence of allergic-type reactions and also to be less effective in group A streptococcal and pneumococcal infections than expected. On the other hand, it has been used successfully in some otherwise unresponsive staphylococcal infections. Even here, however, many strains rapidly become resistant and therefore it is likely that widespread use of this agent would jeopardize even this potential worth.

Cycloserine (Lilly) which has a wide range of activity of a moderate degree against almost all bacteria including Mycobacterium tuberculosis, has not proven to be more than a supplemental drug in tuberculosis and of occasional help in some chronic urinary tract infections. Its central nervous system toxicity has been great.

Two new drugs with anticoccal activity have been introduced. Both of the drugs, however, have the serious drawback that they have to be administered intravenously. The first of these, vancomycin (Lilly), has been shown to be particularly effective in staphylococcal infections, and no serious problems of resistance to it have been encountered.[1,2] The second agent, ristocetin (Abbott), has had its greatest success in enterococcal infections but some success has also been obtained in staphylococcal infections.[3] It, too, has had low toxicity, and resistance to it has not become a problem.

ANTIFUNGAL AGENTS

Two significant antifungal agents have been introduced. Nystatin (Upjohn) (Squibb), the first of these, has its use limited by the fact that it is not absorbed and therefore is most effective against the gastrointestinal carrier state and mucous membrane lesions. The amphotericins (Squibb), however, give promise of being effective in systemic fungal infections as well as the local ones.

In addition to these new agents there have been further studies on preparations which have improved the efficiency of a given dose, the ease of administration, versatility, or some other such factor of the standard agents. The phosphate preparations of tetracyclines are examples of this type of preparation.

In spite of these several gains, however, progress has been slow and most of the problems of five years ago remain essentially unchanged.

Perhaps the most important problem during these years has been that of the antibiotic-resistant strains. In the last 10 years it has become quite clear that much of the problem is caused by spread of resistant strains rather than the development of new resistant forms in patients being treated with the drug. However, three factors—the species of the organism, the drug, and the host suffering the infection—all have an important influence on the occurrence of resistance.

Organisms of a given genera may be uniformly or almost uniformly resistant to a

given drug at the time of its introduction. On the other hand, most of the strains may be sensitive but as the drug is used extensively the minority of the strains which are resistant gradually spread and become predominant, particularly in a "closed" population such as in a hospital or on an army post. This accumulation of resistant strains is the principal way in which the problem of resistant staphylococcal infection has arisen. It is probably also true of many of the gram-negative rods which have been shown to be more resistant than previously.

Of lesser numerical but still of great practical importance is the development of resistance by a given strain of organism in a patient while he is being treated. This phenomenon, which is specific for the drug being used and its analogues, was once felt to be an adaptive phenomenon, but now it seems likely that it is the small number of resistant organisms present in the tremendous total bacterial population which are selected out and multiply if the host defenses are unable to contain them.

RESISTANT STRAINS A PROBLEM

As has been previously indicated, some antibiotics such as streptomycin, the erythromycin-like drugs, and novobiocin give rise to the rapid selection of resistant mutants more frequently than the other drugs. However, with penicillin, and particularly with the so-called "broad-spectrum" drugs, the spread and accumulation of resistant strains has been the greatest problem. One of the most important realizations of the past several years has been that the original concepts on which broad-spectrum therapy was based were fallacious in that the coverage was still incomplete. Consequently, there has been excessive spread of resistant forms secondary to the profound effect on the normal flora by these drugs. This principle seems to be equally valid for all combinations designed for broad coverage.

Two other factors of considerable importance are the host and the environment in which he is situated. Thus, when drugs are being used which leave a relatively large number of resistant mutants behind, if the host is unable to localize and control them, then a resistant infection will occur. On the other hand, a patient treated with an agent in an environment in which many strains resistant to that agent are present is much more likely to acquire one of these strains. This is particularly true of the patient who has underlying disease that makes him more vulnerable to infections with new organisms.

The understanding of the frequency and nature of superinfections is derived directly from the above material. Almost all of these, as would be expected, are caused by organisms resistant to the antibiotic being used. The origin of these are at least threefold. In the first place, many instances of what appear to be superinfections are actually mixed infections before treatment begins. The resistant strains persist, become predominant, and therefore easier to find on subsequent cultures. For example, when multiple cultures were taken before treatment was begun in patients with chronic urinary tract infection, many of the organisms which subsequently became predominant were found in small numbers on some but not all of the cultures. It is obvious then that had a single culture been taken before treatment the organisms might have been overlooked and thus the mixed infection may have been mistaken for a superinfection. Similar results can also be shown in patients with acute pneumonia caused by a mixture of pneumococci and Klebsiella or hemophilus influenza, particularly in patients in whom there is chronic underlying pulmonary disease such as mucoviscidiosis. Here, too, small numbers of the Gram-negative rods may be missed on a single pretreatment culture. We were able to repeatedly demonstrate this phenomenon in patients with poliomyelitis who were tracheotomized.

Among the true superinfections the source of the organisms may be autogenous, such as the spread of Candida from the gastrointestinal tract into the urinary tract. On the other hand, the implantation of resistant strains from the environment are much more frequent. In the case of resistant staphylococci and Gram-negative rod infections, our data on patients with tracheotomies, with leukemia, with urinary tract infections, and with bronchiectasis all indicate that such implantation accounted for well over one half of such infections. Because many superinfections are caused by implants, their incidence depends to a considerable degree on the frequency of resistant organisms in the environment. Therefore, the same principles that go into the spread of resistant organisms govern to some extent the occurrence of superinfections.

Because of the fact that there are still several varieties of failures in the treatment of infection, there have repeatedly been attempts to improve treatment by the use of drug combinations. In spite of the fact that it was recently announced that a new era of antibiotic therapy had arrived, namely, the "combination era," it is obvious that such therapy has been studied ever since the introduction of more than one successful agent. The new era is more in the minds of persons trying to sell extra drugs than in any large number of new indications for such combinations. There are several theoretical reasons for believing that combinations may be more successful than the individual drugs, and several reasonable objections to their use.

COMBINATION DRUGS USEFUL

One of the principal reasons given for using two or more drugs is that the development of resistant strains may be delayed. Thus it has been shown in the laboratory that the number of transfers required to select out resistant mutants was increased by the use of a second drug. This only occurs for certain drugs in certain combinations. For example, Weinstein[4] has shown that sulfonamides will delay the development of resistance of staphylococci to streptomycin, but not vice versa. However, the sulfonamides did not delay the development of resistance to tetracycline, or vice versa.

In spite of these and other variable results the assumption is often made that the delay of development of resistance is rather universal in its application, and this reason still constitutes one of the major ones given for the use of combinations.

Two drugs are recommended in the treatment of tuberculosis where there is frequent selection of resistant mutants by streptomycin, isoniazid, and paraamino-salicylic acid. With the newer drugs (erythromycin and its analogues and novobiocin) for the staphylococcal infections, where selection of resistant mutants has also been rather frequent, combinations are also recommended. In tuberculosis, however, there is evidence that this approach has been successful, whereas in the staphylococcal infection there is no real proof of success.

On the other hand, the wide use of combinations in general makes the resistance problem worse. As previously explained, the major source of resistance in Staphylococcus, and probably many other organisms, is the spread of resistant forms on hospital wards, particularly when large quantities of an agent are being used. Thus the use of an unnecessary drug in a combination only increases the frequency of this type of spread which is the major aspect of the resistance problem. It is safe to say that the routine use of streptomycin with penicillin in some areas has perpetrated and compounded the problem of streptomycin resistant organisms; whereas if only penicillin had been used (except in the small number of patients requiring streptomycin), the incidence of resistant strains to the latter would be much lower and the drug considerably more valuable when needed. We have shown that when pencillin and chlortetracycline were used routinely in combination nothing was accomplished except the accumulation of staphylococci resistant to both drugs in the hospital personnel and patients. Since there were many strains resistant to each drug in the environment when this combination was used, it was felt that the failure may have been because of this. Therefore we felt that if we could use a combination of drugs before there were resistant strains to either of them in the environment the selecting out of the resistant forms would be prevented. For this reason the use of spiramycin and novobiocin as "routine" therapy was studied in one hospital. At the end of four months there was an accumulation of strains of staphylococci resistant to both drugs. In addition, the number of strains resistant to erythromycin and oleandomycin also increased as the result of the use of spiramycin in this combination. In summary, then, as far as incidence of resistance is concerned, the widespread use of most combinations when not specifically indicated will compound the problem.

A second potential reason for the use of combination therapy is the possibility of enhanced effectiveness at a given dose level. That this may occur has been suggested by *in vitro* tests on some organisms showing more rapid and/or complete killing when combinations are used than occurs when twice the amount of the single agent is used. Moreover it is possible that different properties of the agents could lead to a favorable situation in which one agent could reach one area of infection and the second agent a second tissue. On the other hand *in vitro* studies have also shown that at times one drug may act more rapidly alone than when a second

one is added to it. In general, drugs which are bacteriostatic—such as the tetracyclines, chloramphenicol, and erythromycin and its analogues—may either delay or accelerate the killing action of bactericidal drugs such as penicillin or streptomycin, depending on the concentrations used and the species of organism. That some of these factors may be important in treatment has been shown in animal infections where similar combinations have been more or less effective than expected. Which effect is obtained depends on the dose of each drug, the type of infection, which drug is given first, and other factors. One factor in such experiments which has been overlooked is the nature of the dose-response curve. This curve shows that when doses of limited effectiveness are used there is more than a proportionate increase in effectiveness by increasing the dose. Thus, with a given drug, if one dose is 20% effective, doubling the dose may make it 80% effective. Obviously, if such a 20% effective dose is used with a second drug, a similar large enhancement of effectiveness may be observed. Just such a phenomenon has been reported as synergy. This is undoubtedly a misinterpretation. What happens most frequently when two drugs are used together in animals is a somewhat greater effect than when either drug is used alone in the same dose, but simple addition or less than addition of effect if the curves representing the linear relationships between dose and response are used. Synergy when defined as more than this addition is rare. The demonstration of antagonism also requires a precise experimental design in which the dose of the drug being antagonized is kept below the 100% level of effectiveness. As would be expected because of these variable results, it has been difficult to show clinical examples of either enhanced activity or of antagonism. However, our results in pneumococcic meningitis showed that penicillin in large doses was the most effective drug available, but that intravenous chlortetracycline (and probably the other bacteriostatic drugs) given concurrently lowered its effectiveness. These results indicate that in a very ill patient, in whom penicillin is the preferred drug but not uniformly successful, the addition of a bacteriostatic drug may be dangerous. Thus, in the acutely ill child being treated empirically if there is a suspicion of a coccal infection, penicillin plus streptomycin would be a better choice than one of the bacteriostatic drugs and penicillin. Similarly Ström[5] showed that if a borderline effective dose of penicillin was used in streptococcal pharyngitis, the incidence of bacteriologic relapses could be markedly increased by using chlortetracycline in addition to the same dose of penicillin. On the other hand, enhanced action seems to occur when penicillin and streptomycin are used to treat Streptococcus viridans endocarditis, and enterococci infections. It may be the role played by the latter organism that makes the combination so effective in peritonitis. Also, streptomycin plus chlortetracycline seem more effective than either drug alone in the treatment of Brucellosis, although just as good results can be obtained by the prolonged use of tetracycline. In addition, we have studied the combinations of penicillin plus chlortetracycline in respiratory infections, spiramycin plus novobiocin in respiratory infections, streptomycin plus sulfasoxizol plus chlortetracycline in hemophilus influenza meningitis, penicillin plus streptomycin and penicillin plus sulfonamides in pneumococcic meningitis without evidence of benefit from the use of the multiple drugs in any of these situations. Other controlled studies in the literature which were reported to show absence of antagonism, by the same token also show the absence of enhanced effect.

THERAPY MORE RELIABLE

A third reason often given for using combinations is that the "broadening" of the spectrum makes empiric therapy more reliable. Unfortunately, as discussed under the causes of resistant strains and superinfections by them, the broader the spectrum the more apt these are to become dominant. Until the spectrum is broad enough to eliminate all potential pathogens, which essentially means sterilizing the bowel and other mucous membranes, the broad spectrum seems to be detrimental rather than beneficial. It is interesting to note that in six years at the Chicago Municipal Contagious Disease Hospital where penicillin has been the "routine" drug used in patients ill enough to be treated on admission to the hospital with respiratory infections or complication of the exanthemata, less than 1% have required any change to another drug.

One place where a broad spectrum appears to be of use is in mixed infections. Here the more tailor-made and precise the treatment

for each organism the better, since these patients are particularly prone to develop superinfections and overgrowth of one of the strains previously in the minority. It is of interest that a presumed mixed infection in the lung, such as a lung abscess, responds as well to a single agent about as often as it does to multiple agents. Even in acute peritonitis, penicillin when used in large doses gave marked benefit; and the tetracycline used alone gave perhaps slightly better results. However, when associated with anatomic deformities and other factors lowering resistance, mixed infections are apt to become chronic and incurable even when multiple drugs are used. Careful and not cursory laboratory studies to seek the best possible therapy for such patients are mandatory before giving up hope, even though the quest is often futile.

DRUG DOSAGE

It is obvious, however, that when one uses a combination of drugs to treat a mixed infection each drug should be used in its optimal dose for the organism for which it is being used. This generally means a full therapeutic dose and not a fixed ratio such as the penicillin streptomycin preparation, where in severe infections an overdose of one drug will occur if the optimal dose of the other is used.

In the local use of the relatively toxic drugs for mixed infection, combinations are often employed. Thus in the preoperative bowel preparation various combinations are frequently given. As long as the non-aborbable drugs are being used this procedure does little to alter the flora in other areas than in the gut; therefore less risk is entailed. In many similar situations other than bowel preparation, which is a most rigid test because of the many strains involved, the evidence for need of combination therapy is not forthcoming.

The problem of enhanced toxicities with multiple drug therapy is not well documented. However, it is clear that whenever the allergenic drugs like penicillin, novobiocin, streptomycin, and the sulfonamides are used unnecessarily in combinations or otherwise, there is danger of needless sensitization. This may be particularly true in pediatric practice. Even though children react less frequently, the seed for future reaction is sown in them.

COMBINATION DRUG THERAPY

In summary of the problems connected with combination drug therapy, it seems that there are four times that their use is indicated: (1) when there is known mixed infection requiring several agents; (2) in a small number of infections in which the results are inadequate with single drugs in the maximum tolerated dose; (3) in a handful of conditions in which enhanced activity has been demonstrated, principally enterococcic infection and heart infection with Streptococcus viridans; and (4) in an attempt to delay the development of resistant strains under the impact of therapy, particularly in tuberculosis and perhaps in staphylococcal infections. When two or more drugs are used in mixed infections and in those in which maximum doses of single agents have failed, each drug should be given in the optimal dose to accomplish its purpose. This generally means a full therapeutic dose. Consequently fixed-ratio formulations have little to recommend them, and it is usually better to order each drug independently in the proper amount. It is patently evident that the extensive use of more than one drug per patient will make the problem of accumulation of resistant strains even worse than the extensive use of single drugs. Thus it is mandatory that such therapy be held to the minimum required by the several indications. In addition, unnecessary toxicities are occurring, such as deafness from the use of dihydrostreptomycin in combination with penicillin when the latter alone would have been adequate.

Another problem area somewhat akin to the foregoing is the prophylactic use of antibiotics. In general it is possible to prevent implantation of a very sensitive pathogenic organism into relatively healthy tissue. In fact it is considerably easier to prevent the implantation of an organism like the group A Streptococcus than it is to eliminate it after infection has occurred. Thus smaller doses of penicillin and even the sulfonamides which are of small effect in the treatment of streptococcal infections will be quite adequate in the prevention of them. On the other hand, in patients whose natural resistances are impaired and in whom the implantation of many less virulent organisms may cause difficulty, the use of prophylaxis is much less successful because of implantation of the more resistant strains.

Thus the almost uniformly successful prophylactic use of drugs in rheumatic fever patients needs to be contrasted with the difficulties with resistant staphylococci and pseudomonads, etc., in patients with bronchiectasis. The latter may be protected from the streptococci and pneumococci but not against the secondary invaders. Therefore the results are much less successful, and maintaining these children in reasonable health requires constant surveillance and treatment of repeated exacerbations. Unfortunately, we have not been able to confirm that small doses of tetracycline protect these patients against a wide range of pathogens.

Moreover as suggested by Weinstein,[6] when a patient's resistance is lowered by the invasion of an acute infection such as measles, the use of antibiotics prophylactically may actually increase the frequency of secondary infection. It is quite certain that the causative agent of the complicating infection will be altered. Thus staphylococcal pneumonia and empyema have been more frequently seen by us in the last two measles epidemics than in the preceding two. It can be seen then that among patients not on prophylaxis some will develop bacterial complications such as pneumococcal pneumonia or streptococcal otitis. A very small number may also become infected spontaneously with resistant organisms. If the patients are carefully watched, the common bacterial complications can be treated promptly and the results are almost uniformly successful. A small percentage of these treated patients will develop superinfections with resistant organisms. On the other hand, when prophylaxis is used only a few patients will develop the usual bacterial complications but a small percentage of the *total* group will now manifest a superinfection with resistant organism. It is most likely, therefore, that these difficult-to-treat infections are more frequent, probably as high as 5 to 10 times as many in the group receiving antibiotics routinely. Weinstein's figures tend to confirm this, although proper controls for this type of measurement are difficult to obtain.

The problems encountered in the prophylactic use of antibiotics are therefore basically concerned with rates of infection in groups of patients, with different host resistances, altered by pathologic conditions, living in different environments with varying proportions of potential pathogens of varying antibiotic sensitivity. It is clear that it is difficult to predict the situations in which prophylaxis will be of value; therefore, the answer must be found by controlled studies in each pathologic condition in various environmental situations. This has been done in the case of prevention of streptococcal infections in children who have had rheumatic fever. On the other hand, in adults with rheumatic heart disease and congestive heart failure, the local resistance is such that the incidence of superinfection may be higher. Although we do not believe prophylaxis should be withheld in these patients on this account, we have seen staphylococcal pneumonia in two such patients. Prophylaxis for ophthalmia neonatorum in infants and gonorrhea in the adolescent and adult is also successful. Sulfonamide prophylaxis for meningococcal infections and bacillary dysentery has also been highly valuable in healthy populations. In other situations the indication must be carefully weighed. Thus in bronchiectasis and similar chronic disease the condition of the patient, the frequency of acute exacerbations, the environment in which the patient is living, etc., also should be considered.

BRIEF PROPHYLAXIS

Brief prophylaxis is a simpler problem. The preparation of the patient for surgery, for which treatment is used for only a few days, is less apt to be complicated by secondary invasion of resistant strains. Hence the success of this type of prophylaxis stands in contrast to the failure of therapy to protect the patients on whom indwelling catheters are used for a prolonged period.

It is now possible to re-examine the three large problems stated initially, the first of which, concerned infection caused by organisms which had been refractory to treatment. It has been seen that recent discoveries have furnished tools to cure some of these. However, progress has been slow in proportion to the effort expended. The second approach, that of combining drugs, has had some success; however, there are still many instances in which infections persist. On the other hand, none of these patients should be considered untreatable until they have been carefully studied. Correctable host factors should be sought. If surgery is contemplated, antibiotics should be designed for maximum ameliorating coverage of the surgical procedure. The organism or organisms should be

classified completely and sensitivity tests carefully done by a rigidly standardized disk, or better, a tube on plate method. The best possible therapy should then be chosen and given a trial in maximum dose with close observations, looking for evidence of improvement and of superinfection or relapse so that appropriate duration of treatment can be judged or suitable changes can be made. If this type of therapy fails one can be reasonably sure that no other treatment will succeed. It is important that the laboratory personnel be encouraged to put in maximum effort with adequate methods on these problem patients. To do this they should be relieved of much of the routine, unnecessary testing of every organism with inadequate methods which is currently so frequent. Since injudicious use of the antibiotics is often related to the spread and accumulation of resistant strains and even the development of new resistant strains and infections by them, mitigation of the problem would occur if the drugs were used more precisely only in infections in which their worth has been established or when the illness is critical and a treatable condition cannot be reasonably discounted.

Many of the facets of the second problem, namely infections complicating other diseases which are often chronic, have been considered. These infections are often caused by resistant organisms and therefore have been partially discussed. They are also frequently mixed infections and properly chosen combinations as outlined above may be effective. The adequate integration of antibacterial with other corrective therapies is all important. The difficulties of prophylaxis in this group have been discussed. It is possible to prevent some of the high-grade pathogens from invading by the use of treatment similar to that for the prevention of streptococcal infections in rheumatic fever patients, but attempts to prevent much more than this generally create rather than mitigate difficulty.

The third problem, that of diagnosis and proper indications for therapy, is, of course, the key. It is obvious that the panacea of using antibiotics routinely for all fevers and for prophylaxis in respiratory infection or chronic diseases is not a good substitute for thoughtful consideration or management. In this regard "broad spectrum" treatment has failed. One may look for example at the respiratory infection situation. Obviously the physician's ability in diagnosis is all important in finding the child who has otitis media, purulent sinusitis, or pneumonia that requires treatment. The major problem occurs when none of these conditions are present but when the patient has pharyngitis or tonsillitis. Here it has been evident that almost the sole reason for treatment is streptococcal infection. It is also evident that to treat this properly 10 days of an effective drug concentration is required and the sulfonamides should not be used. What is all too often done is that the patient is given several drugs for a few days and then therapy discontinued. This is overtreatment for the 80 to 90% of patients without Streptococcus and undertreatment for the important group. Such use can only lead to difficulty and almost complete negation of the potential worth.

The concluding thought, then, is that some elements of the pharmaceutical industry are increasingly cynical about the practitioners. Advertising can be misleading if taken at full face value. Our answer must be that only the thoughtful physician can use the agents correctly. All of the sales "gimmicks" and brightly decorated ads put together have not cured a single patient.

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Clinicopathologic Conference

Sponsored by the Section on Pathology, State Medical Society of Wisconsin
Guest Editor: E. A. Brucker, M. D.

CASE PRESENTATION*

Dr. E. E. Skroch: This is a case of a 30-year-old white female who was admitted to the hospital on December 19, 1953, with a two-day history of abdominal pain. She was in good health until December 17, when she had a sudden onset of sharp pain in the right lower quadrant. A 30-year-old female with a sudden onset of abdominal pain would make one think of many possibilities that could cause a sudden onset of pain; most common would be a ruptured ovarian cyst or a ruptured ectopic pregnancy. She had a forced emesis without relief. Soon the pain became generalized, which would make one think of fluid or blood in the peritoneal cavity with a rapid diffusion throughout the peritoneal cavity since she had slight abdominal swelling. This was followed by weakness. She denied nausea and vomiting except on the one occasion already noted. The following day weakness increased and the pain was fairly progressive but not acutely progressive. An abdominal x-ray revealed dilatation of the large bowel which could have been on a reflex basis, that is, a paralytic ileus due to spilling of contents into the peritoneal cavity. She received supportive therapy.

PHYSICAL EXAMINATION

On admission, the pain was localized to the lower abdomen. She did not have a bowel movement but had been passing gas per rectum. This would tend to indicate a slowing of the peristaltic activity without true mechanical obstruction.

Menstrual history revealed that she was gravida IV, para IV. Her last menstrual period had been December 6 to December 10. The protocol mentions only that there was a four-day period in December, that it was normal, but doesn't say whether it occurred at the usual time.

The patient was a well-developed, well-nourished, pale female in moderate distress. Blood pressure was 64/38, pulse 132, and from this I think we can state that she was in severe shock. Her temperature was 100 F. Skin was dry and dehydrated. The remaining examination of the upper part of the anatomy was essentially negative. The abdomen was distended, diffusely tender with guarding; no masses and no rebound tenderness was noted. Bowel sounds were active. This is a little unusual since in cases of intraperitoneal bleeding or spilling of contents into the peritoneal cavities one expects the patient to have rebound tenderness and rigidity. There should be marked irritation of the peritoneal surfaces and the rebound should be quite marked. Here, however, we had no rebound tenderness; however, there was slight tenderness noted throughout the abdomen. The bowel sounds were hyperactive which would indicate irritation to the peritoneal surface. Paralytic ileus occurs later. Pelvic examination showed a multiparous cervix which was smooth, nontender on movement, and showing a blood-tinged mucoid discharge. No adnexal masses or tenderness was noted. Rectal examination was not remarkable. The extremities and neurological examinations were noncontributory.

She was immediately given plasma and glucose in saline with a prompt rise in the blood pressure to 112/52 and the pulse slowed to 120. A Cantor tube was passed. Supportive therapy was continued the first night in the hospital. In the morning she felt much better and had no pain. Bowel sounds were present and she was passing some gas. Laboratory examination at this time showed less than 7.5 gm. of hemoglobin. Her white blood cell count was 16,350. Blood chemistries showed a lower limit of normal for the electrolytes. The report of less than 7.5 gm. of hemoglobin certainly is inadequate as it could be much lower. The white blood cell count of 16,350 might indicate infection;

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still if there is peritoneal hemorrhage it also could be elevated, especially from a tubal pregnancy. The second day, which was December 21, her red blood cell count was reported at 640,000 which is very, very low for a patient that is still living. The color index was 1.1. Her white blood cell count was up to 19,000 with a shift to the left. The patient must have been in excellent physical condition to tolerate such a severe degree of anemia.

On the same day she was given her first blood transfusion. At this time she denied abdominal pain for at least 16 hours. She was still pale but fairly comfortable, slightly dyspneic, and lying flat in bed. Blood pressure was 118, pulse 128 and regular, and temperature 102 F. No petechiae were noted. The sclera were nonicteric. Her hydration had improved considerably since her admission. The chest was clear. The heart rate was regular at 128 with a soft, apical, systolic murmur. The abdomen was slightly distended with bulging flanks and was tender throughout with guarding. Bowel sounds were now absent. Rectal examination showed some tenderness but no palpable masses. Brown stool was obtained on examining with the finger.

Gynecological consultation was obtained. The patient had denied any shoulder pain or abdominal pain on moving from side to side. Shoulder pain occurs with intra-abdominal hemorrhage due to blood under the diaphragm. The pain is usually referred to the left shoulder; however, occasionally, blood is seen up over the surface of the liver and then the pain would be referred to the right shoulder. Examination revealed rebound tenderness over the right lower quadrant; note that early examination did not reveal any rebound tenderness. A positive Chadwick's sign was present which is a sign of pregnancy, producing a bluish discoloration of the cervix. There was also a mucosanguineous discharge from the cervix, increased heat in the vaginal vault, and pain on motion of the cervix. However, no mass was identified in the cul-de-sac. Pain on motion of the cervix is a very common sign in tubal pregnancy or ruptured tubal pregnancy and causes marked pain in the abdomen. No masses in the cul-de-sac should help to rule out ovarian pathology such as a twisted ovarian cyst. Here culdoscopy or needle aspiration would have been helpful in confirming the presence of blood in the cul-de-sac. The uterus and adnexa were not outlined due to the abdominal tenderness. Blood count at this time showed a hemoglobin of 6 gm., a red blood cell count of 1,940,000, and a color index of 1. The reticulocyte count was 6.6%; platelet count was over 100,000; and there was one normoblast per 100 white blood cells. The total bilirubin was 1.3 mg.% and the direct reading was 0.25 mg.%. Bone marrow examination at this time showed a granulocytic and normoblastic hyperplasia. She continued to improve. The Cantor tube was removed and she was taking oral fluids. The abdomen was soft and nontender, this was on December 26. During the past three days she had been receiving daily blood transfusion. There was stated to have been a normal stool and flatus. The abdomen was nontender; however, it remained distended. On December 28 she was again seen by the gynecological service. The findings were unchanged from the original examination except for a decrease in abdominal tenderness. She could eat well but remained febrile. Because of obvious loss of red blood cells from a nonvisable source, she was given two more units of red cell mass on December 29 for survival studies. She continued to feel well and on December 31 an exploratory laparotomy was done.

RESULTS

The results of her laboratory data at this time were as follows: On December 28 the hemoglobin was 5 gm.; red blood cell count, 1,790,000; reticulocyte count, 17.8%; alkaline resistant hemoglobin, 1.7%; electrophoretic pattern for hemoglobin determination was normal; a Coombs' test was negative; plasma hemoglobin was under 5 mg./100 cc. of plasma; cold agglutinins test was negative; 24-hour urine for urobilinogen showed 5 mg. in 24 hours; 24-hour stool examination for urobilinogen showed 200 mg. in 24 hours; and the urine for hemosiderin on two occasions was negative.

The important thing we have to discuss here is: What did they find at laparotomy? As you note, there was a large amount of laboratory work done which would indicate that someone was thinking of a primary anemia. To me the picture was that of a blood loss anemia responding to blood transfusions. The white blood cell count had gradually returned to normal with a normal

differential. The reticulocyte response was what one would expect from blood loss. The blood chemistries do not help us. The bilirubin test showed a slight increase in the indirect fraction which could be from hemolysis or transfused blood. The results of the bone marrow examination were certainly compatible with a person who was losing blood. The urine tests were negative. The special tests appear normal.

This, then, is a case of a 30-year-old woman who has lost a tremendous amount of blood somewhere without the usual signs of intra-peritoneal bleeding, namely that of marked rebound tenderness and abdominal pain. It was fairly rapid loss of blood, the type which would be seen with a ruptured tubal pregnancy or a ruptured follicular cyst or a ruptured ovarian cyst. In most conditions the bleeding is usually quite progressive, with shock and a steady downhill course.

In the differential diagnosis I have discussed the gynecological problems. First of all, I think the most common condition we see in a 30-year-old female, in spite of the fact that the history here gives a normal menstrual period, is bleeding from a tubal pregnancy. This, of course, can be an extremely difficult diagnosis. Usually, however, there is a history of a missed period or a delayed period followed by abdominal pain, but as we all know a woman's menstrual history can be very unreliable. The finding of pain on motion of the cervix, a positive Chadwick's sign, marked loss of blood, and tenderness of the abdomen would certainly go along with a ruptured tubal pregnancy. Other gynecological conditions which I have seen on several occasions are a ruptured follicular cyst or ruptured corpus luteum cyst where surgery was necessary because of blood loss and shock. Here again, though, with bleeding into the peritoneal cavity we would expect to find more positive physical findings. Other conditions that we must consider and rule out would be a bilateral hydrosalpinx. This, however, would hardly produce this severe an anemia and this woman already has four children which would be extremely unusual for a woman with hydrosalpinx; in most instances these patients are sterile. The possibility of a ruptured spleen must be considered. Here we have no history of injury or trauma; but spontaneous ruptures of the spleen can occur, especially with infections of the spleen such as infectious mononucleosis. However, there appears to be no evidence of this being present. There are rare and remote possibilities of diseases that can cause rupture and bleeding, such as various cysts and tumors in the gastrointestinal tract or the liver; but again the history and physical findings in this case do not indicate any of these conditions. Therefore, I will leave this as a tubal pregnancy that has ruptured, possibly into the broad ligament so that there is no early bleeding free into the peritoneal cavity, followed later by extensive hemorrhage into the abdominal cavity accounting for the physical findings and anemia in this case.

Dr. T. V. Geppert: I think that with diffuse blood loss and no typical findings one should consider a hemolytic anemia in the differential diagnosis. However the laboratory reports, if they are correct, would certainly rule out this possibility. The negative Coombs', normal hemoglobin pattern, no remarkable changes noted on the peripheral smear, and the normal stool urobilinogens would certainly be adequate in ruling out the possibility of a hemolytic anemia.

Dr. F. G. Joachim: This is a fairly typical picture of acute blood loss and hemorrhage without the usual findings of the source of hemorrhage. We have had in the past a clinicopathologic conference at this hospital in which the patient had a ruptured aneurysm of the splenic artery, so that I think a ruptured vessel should be considered in this case.

PATHOLOGICAL DISCUSSION

Dr. E. A. Brucker: Before getting into the anatomical features of the case, several doctors have asked the meaning of some of the laboratory tests that were reported on the protocol. The alkaline resistant hemoglobin is a test to determine the presence or absence of fetal hemoglobin. It is commonly elevated in congenital hemolytic anemias, thalassemia, acquired hemolytic anemia, and occasionally in pernicious anemia in relapse. Of course, it is always present in newborn babies. The electrophoretic pattern of hemoglobin was done to rule out the possibility of a hemoglobin disease. The hemoglobin pattern was normal; this is called adult hemoglobin. The Coombs' test was negative which helps to rule out the acquired auto-immune hemolytic anemias. Plasma hemoglobin is an-

Fig. 1—Cross section of the fallopian tube showing an area of hemorrhage, placenta, and fetal membranes.

other test for hemolysis. Cold agglutinins are sometimes present in hemolytic anemias and in other conditions, such as atypical pneumonias. Both urinary and fecal urobilinogen are done to determine the presence of hemolysis. Here again both these determinations were normal. Fecal urobilinogen is a very good test in determining hemolytic anemias; a level over 250 mg. is considered to be of extreme importance; levels may go up to 500 to 1,000 mg. per day. However this is not a pleasant laboratory test for the technologists. I would like to use other methods before doing the three-day stool examination. As you noted these tests were all within normal limits which would rule out a hemolytic disease. This apparently was the primary concern of the attending physician and after this was ruled out the patient was taken to surgery.

The anatomic findings were as follows: The abdominal cavity contained about 1,000 cc. of blood and a large amount of blood was noted in the broad ligament. The fallopian tube was enlarged and had a dark bluish color. A major part of the tube was destroyed with dark hemorrhagic tissue. The fallopian

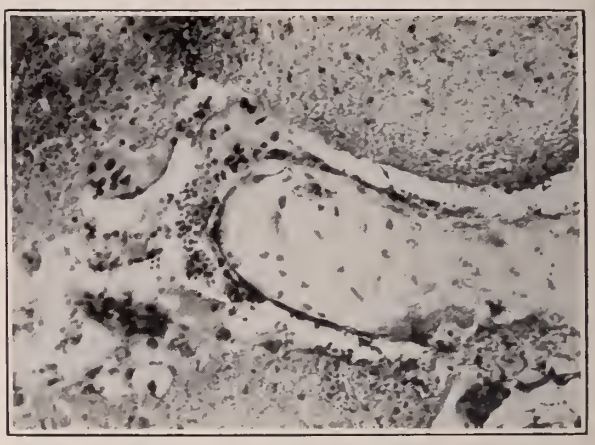

Fig. 2—Photomicrograph of the tube wall showing a placental villus associated with hemorrhage and necrosis. x360.

tube on cross section showed a large area of hemorrhage with fetal membranes and placenta identified (fig. 1). Microscopic examination of the tube wall showed areas of hemorrhage, inflammatory cells, and placental villi (fig. 2).

This is a case of a ruptured tubal pregnancy with bleeding into the broad ligament followed by intra-abdominal bleeding. The basic cause of rupture is felt to be the invasion and extension of the placental villi through the thin muscular wall of the tube associated with hemorrhage. The death of the fetus probably results from the hemorrhage that occurs in the tubal wall with separation of the placenta; also intra-tubal bleeding itself could lead to anoxia with death of the fetus before rupture occurs.

GOLF TOURNAMENT

The American Medical Golfing Association is holding its annual golf tournament in conjunction with the A.M.A. convention on June 23, 1958, at the beautiful Olympic Lakeside Golf and Country Club, San Francisco, California. This will be a whole day of rest and relaxation with golf, luncheon, banquet and a prize for everyone. Tee off time starts at 8 o'clock in the morning until 2 o'clock in the afternoon. A cordial invitation is extended to all golfing doctors to attend. Handicaps scratch to 30 in flights.

For information, contact James J. Leary, M.D., Secretary, 450 Sutter Street, San Francisco, California.

Historical Summary of Medical Progress in Wisconsin*

By A. J. McCAREY, M. D.
Green Bay

IN THE early days the gateway to what is now known as Wisconsin was located at Green Bay,[1] or as it was known at that time, as "La Baye." The first white man to set foot on the soil of what is now known as Wisconsin was Jean Nicolet. He landed on the shore of the bay in 1634, 14 years after the Pilgrims landed on Plymouth Rock. He was looking for a route to the Orient and was dressed in a gown of embroidered silk damask and carrying a pistol in each hand as he stepped ashore. His disappointment can be imagined when he was met by only a horde of naked savages, whose women and children ran away in fright from the "strange being who carried thunder in both hands." Nicolet was followed some 20 years later by Radisson and Groseilliers who were the first traders and the founders of the Hudson Bay Fur Company.

The Jesuit missionaries were the next to come, Fathers Allowez, Dablon, Marquette, and other brave and fearless priests. They established the Mission of St. Francis Xavier at the Rapides des Peres, five miles up the river where the city of De Pere is now located. They were followed by fur traders, the coureurs de bois, and the voyageurs. During the French occupation Fort St. Francis was built and named in honor of the Mission.

In 1761 the English took over and rebuilt the fort naming it Fort Edward Augustus, who was a brother of George the Third. The English ruled until 1816 when an American force sailed into La Baye, took command, and built Fort Howard which was named in honor of General Benjamin Howard who commanded the western country during the War of 1812.

During all of this time the natural waterway up the lower Fox River, into Lake Winnebago, into the upper Fox, across the mile-long portage, and down the Wisconsin river to the Mississippi at Prairie du Chien, was being used for travel by the explorer, the missionary, the trader, and later the settler. A fort was built by the French at Prairie du Chien about 1683 and was named Fort St. Nicholas. In 1780 the British built a fort on the shore of the "Pig's Eye", a narrow body of water between the island and the Prairie on the Wisconsin side of the river. The Americans came in 1814 and built Fort Shelby, named in honor of Isaac Shelby, the governor of Kentucky. In 1816 a new fort was built and called Fort Crawford in honor of William Harrison Crawford, Secretary of the Treasury of the United States. In 1831 a new Fort Crawford was built on higher ground because of the flooding of the lower ground by the river. It is The Military Hospital at this fort that the State Medical Society has acquired and there are now plans for a Wisconsin Medical Museum on this historic spot.

BUILD FORT

At the Portage a fort was built about 1828. It was built by the First Infantry then stationed at Fort Howard. It was called Fort Winnebago. It is natural to assume that outside of the Indian Medicine Man who ministered to the members of his tribe with incantations and ceremonial dances, there was no medical care in this region, except perhaps what little medical knowledge the missionaries brought with them and which they transmitted, when necessary, along with their spiritual ministrations.

With the coming of the military, medical care was dispensed to the people who lived or traveled along this famous waterway by the surgeons stationed at the forts to care for the soldiers and their families.

In 1830 United States Commissioner James Duane Doty planned two military roads, one from Fort Howard to go by way of Manitowoc and then along Lake Michigan to Fort Dearborn, the other to Portage and thence to Fort Crawford. This latter trail, for it was little more than that, followed the Fox river from La Baye to about where

* Presented before the Section on Medical History, One Hundred and Sixteenth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, May 9, 1957.

Wrightstown is now located, then turned south along the eastern shore of Lake Winnebago to Fond du Lac, and from that point west to Portage. It then turned south again to Lake Mendota going along its northeast shore and thence westward to Prairie du Chien.

The story is told "that in 1837 the army surgeon from Fort Winnebago at Portage went to Madison to give medical aid to the mother of A. A. Bird. On a bitter morning the surgeon and some others left on the return trip to Fort Winnebago. When the travellers had gone about half way the surgeon was so cold that it was necessary to stop in the timber and build a fire. The surgeon was so cold he could not speak. He was carried to the fire, rubbed a long time, given a little brandy, and then was able to resume the journey. When the fort was reached the thermometer registered thirty-two degrees below zero."

The first surgeon at Fort Howard was Dr. William S. Madison of Virginia. In 1821 while he was on his way by land to Fort Dearborn at Chicago, he was shot and killed by his Indian guide because of a grudge. He was succeeded by Dr. Walter Wheaton who was later transferred to West Point. Wheaton was succeeded by Dr. William Beaumont who came to Fort Howard from Mackinac in 1826. At the latter place he had already started his epoch-making experiments on the stomach of Alexis St. Martin, which were interrupted when St. Martin departed for Canada. During Beaumont's two years' stay at Green Bay he reported the need of many repairs and the lack of necessary surgical instruments. The hospital was put in good order as a result of Doctor Beaumont's observations. He was succeeded by Dr. Lyman Foote who in turn was followed by Dr. Richard H. Satterlee.

At great personal expense, Doctor Beaumont went to Fort Crawford from Fort Howard in 1829, having learned of St. Martin's whereabouts. He brought him to Prairie du Chien and continued his experiments until March 1831 when St. Martin again left for Canada. St. Martin rejoined Beaumont in 1832 and the experiments were continued until November 1833.

It might be interesting to state here that Doctor Beaumont never attended a medical school. He studied with a preceptor and was licensed to practice medicine on the second Tuesday of June 1812, by the Third Medical Society of Vermont as by law established. "Doctor Beaumont possessed great firmness and determination of purpose. He was gifted with strong natural powers, which working upon an extensive experience in life resulted in a kind of natural wisdom." Thus given an Alexis St. Martin he was able to use this opportunity to the utmost and make his great contribution to scientific medicine in America.

WISCONSIN BECOMES TERRITORY

On the fourth of July, 1836, a bill was passed creating the territory of Wisconsin, its name being derived from its principal river called by the Indians, Meskousing, meaning the river of the flowering banks. Wisconsin was beginning to grow. Mineral Point in the southern part of the territory had a population of almost two thousand. It was the center of the lead mining district and the location of one of the two land offices that were set up when the government concluded a treaty for the purchase of extensive territory. Mineral Point was the location of the land office in the Wisconsin district. Green Bay was the location of the land office in the Green Bay district.

The physicians who served these early settlements, like the settlers they cared for, were usually driven westward from the eastern seaboard by poverty and the hope of better prospects elsewhere. Few had actual medical degrees. Some were even imposters.

A quotation from the personal recollections of Theodore Rodolf found in Dean Susan Burdick Davis' book, "Old Forts and Real Folks," should be interesting at this point.[2] Mr. Rodolf came to Wisconsin in 1832 and settled in La Fayette county. In the later years of his life he lived in the city of La Crosse and at one time served as its mayor. He is quoted as follows: "Previous to leaving Switzerland our family physician prepared for me a medicine chest containing all the simple drugs and medicines which were most likely to be of value to us during our journey. We found this a valuable contribution to our comfort. In some way this fact became known in our neighborhood, at Hamilton's settlement, and soon I had calls for help from near and far. I gave of my supplies as long as they lasted, never taking any compensation; therefore I was soon known throughout the country as Doctor Rodolf and was so called

by my friends in Galena and by all the older settlers. I was advised by my friends to set myself up as a physician. There was no law preventing my doing so and I was assured of a fair practice, but I could not do it. I had but too recently arrived from Europe and lacked the imprudence necessary for a successful imposter."

The doctors who practiced medicine in Wisconsin in the nineteenth century developed from preceptorships and from attending a session or two at the young medical schools that were beginning to make their appearance. During the first half of the century their therapeutic mainstays were bleeding, emetics, and purges.

Fielding H. Garrison in his "Contributions of the West to American Medicine" says, "Let us lift our hats to the frontier physician East or West with reference to his first important contribution to American Medicine; namely, risking his own health in mud, swamp, and mire, enduring poverty and all manner of personal discomforts and privations in an honest endeavor to cure these sickly people."[3]

NEAREST MEDICAL SCHOOLS

The nearest medical schools to Wisconsin were located in Chicago.[4] The first one founded in 1843 was Rush Medical College named after Dr. Benjamin Rush, one of the signers of the Declaration of Independence. Another was the Chicago Medical College which was started by Dr. Nathan S. Davis, who also became the first editor of the *Journal of the American Medical Association.*

These colleges and others like them were proprietary institutions depending for their existence upon the fees paid by students. Their school terms were limited to about 16 weeks during the winter months, and the course of study consisted of two such terms. The subjects studied in the first year being repeated the second year. To these schools came many young men from the log cabins and farm homes of Wisconsin, who in the latter part of the ninetenth century brought distinction to themselves and added their measure in making Chicago a center for medical research. Among them were Senn, Hektoen, Favill, Murphy, Billings, Sippy, Ochsner, Tice, and others.

Across the Atlantic ocean during all of this time there was remarkable progress being made in medical research into the causes of disease. Louis Pasteur, Joseph Lister, Robert Koch, and others made their discoveries by means of which modern medicine, surgery, and public health work were transformed. Many medical men journeyed to Europe and brought back knowledge, instruments, and laboratory equipment.

Medicine became divided into specialties, and medical colleges added the necessary different departments and increased the length of the course of study.

PHYSICIANS EASY TO RECOGNIZE

At the end of the nineteenth century the Wisconsin physician for the most part was bearded or wore some variety of hirsute adornment on his face. A few still wore high stiff hats and Prince Albert coats. All had the aroma of iodoform about them as they made their calls. They were all quite adept in the art of medicine and were gradually making use of the changes in practice brought about by the advancement of medical science.

The coming of the twentieth century marked the influence on the practice of medicine of the many inventions that changed the methods of living of all Americans—electric lights, the telephone, the invention of the gasoline motor, hard surfaced roads—all played their part.

At the same time the development of the modern hospital with organized staffs and standardization programs sponsored by medical societies gave the doctors workshops in which all of the wonders of modern medicine and surgery could be practiced.

The widespread epidemics of yesteryear began to disappear through improved sanitation, antitoxins, serums, and vaccines. With the coming of the sulfonamides and antibiotics the doctor became powerful indeed, being able to actually destroy the germs of disease in the individual patient. He makes full use of insulin and liver extracts and his increased knowledge of biochemistry. He makes use of x-rays, electrocardiograms, basal metabolism determinations, and other diagnostic procedures. The patient of today knows full well that he has in the modern doctor one who is able to do more for him than has ever been done before in all human history.

I come now in closing to the important part played in medical progress by medical

societies in general and the State Medical Society in particular.[5]

In 1841 the Medical Society of the territory of Wisconsin was founded by an act of the territorial legislature.

In 1850 the Bureau of Vital Statistics was asked for from the Legislature.

In 1856 the Legislature was asked to build a hospital for the mentally ill.

In 1860 *The Wisconsin Medical Journal* was established.

In 1876 the Society, through the Sauk County Medical Society, was successful in having a bill passed establishing the State Board of Health.

In 1889 the Society's bill for the establishment of a State Board of Medical Examiners was defeated in the Assembly, but

In 1897 a bill to accomplish this was finally passed.

In 1903 a resolution was passed initiating the movement for establishing tuberculosis sanitaria.

In 1916 a committee was appointed to study compulsory health insurance.

In 1919 an endowment of one million dollars from popular subscription and a gift from the Carnegie Institute was created for Marquette University School of Medicine.

The same year the Board of Regents of the University of Wisconsin made provisions for the establishment of a complete medical school.

In 1937 and 1938 the Society conducted studies in the distribution of health services and sickness care in Wisconsin, and George Crownhart was authorized to make a study of sickness insurance in Europe. From 1938 to 1941 experiments were conducted by the Society in Superior, Milwaukee, and Rock counties.

These are only a few of the many accomplishments of the State Medical Society in the interest of the health and welfare of Wisconsin citizens during its first hundred years of existence.

What has been done since 1941 is fresh in the minds of most of us. The voluntary health insurance plan administered by the Wisconsin Physicians Service, known as Wisconsin Blue Shield, is one of its most notable accomplishments. The organization of the Charitable, Educational, and Scientific Foundation is another.

But in a meeting of the Section on Medical History, I must not fail to mention the acquiring of the Old Fort Crawford Military Hospital at Prairie du Chien, and the plans being made for the establishment of a Wisconsin Medical Museum which I have mentioned before. This Museum will honor Doctor Beaumont as well as Dr. Walter B. Cannon of Prairie du Chien, and the lives and works of many other Wisconsin physicians of the past, present, and the future.

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610 Northern Building.

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Invitation to National Convention American Society of Medical Technologists

The American Society of Medical Technologists has extended an invitation to the members of the State Medical Society of Wisconsin to attend the sessions of its national convention to be held June 15–20 at the Milwaukee Auditorium. No registration fee will be charged any medical doctor. However, the people at the registration desks will be instructed to request identification in order to avoid possible embarrassment. For any special events (e.g. seminars, tours, or social events) there would be a regular fee.

Further information may be obtained by writing the American Society of Medical Technologists, Executive Office, Suite 25, Hermann Professional Building, Houston 25, Texas.

Q Fever in Wisconsin

As It Looks to Your State Board of Health

DURING the past several years studies carried out at the State Laboratory of Hygiene have revealed the presence of Q fever in Wisconsin cattle and have circumscribed the geographical area of infection in the state. Evidence of human infection in certain high risk occupational groups was also found by serologic surveys. In view of the potential hazard of Q fever in human health, a summary of these studies, reported elsewhere in detail[1], is presented. Since little information was adduced regarding the extent and severity of human infection, the cooperation of physicians, particularly in the area to be described, is requested in the continuing search for clinical cases of human Q fever. Serum specimens from suspect cases may be sent to the state laboratory for specific tests. Accumulation of such data may lead to a better understanding of the role of Q fever in human disease in Wisconsin.

An important epidemiologic feature of Q fever in most areas where it has occurred has been its association with livestock or their products. In the United States the relationship between naturally infected livestock and human disease was most clearly defined in California. Here Q fever was found to be highly endemic; in the southern part of the state the source of many human cases was ascribed to naturally infected dairy cattle and in the northern region, to sheep and goats.

In view of this relationship, the endemicity of Q fever in the large dairy cattle population of Wisconsin was considered and studies were undertaken to investigate this possibility. Sera from cattle were obtained through the cooperation of the Animal Disease Diagnostic Laboratory of the Wisconsin Department of Agriculture and were tested for Q fever antibody by the complement-fixation test. In June, 1956, a serologic survey of the entire state was completed in which a statistically significant number of cattle from each of Wisconsin's 71 counties had been tested. The results of this survey showed that serologic evidence of Q fever infection was present in cattle in 9 contiguous counties in the southeastern part of Wisconsin. These were Kenosha, Walworth, Waukesha, Rock, Racine, Dodge, Jefferson, Fond du Lac and Sheboygan. In this area an average of 8 per cent of the cattle had serum antibody to the Q fever rickettsiae (*Coxiella burneti*) as compared to only 0.35 per cent in the other 62 counties and individually the 9 counties had percentages ranging from 22.3 (Kenosha) to 1.2 (Sheboygan). Many of these animals had high Q fever antibody titers and also several cows within a single herd usually showed serologic evidence of infection.

Attempts were then made to substantiate the serologic evidence by demonstrating the presence of the Q fever rickettsiae in the raw milk of several cows with complement-fixing antibodies. Three herds from two counties (Walworth, Rock) were chosen for study. Approximately 50 per cent of the cows within each of these herds had had complement-fixation reactions to Q fever antigen in titers ranging from 1:40 to 1:640. Milk specimens were collected from 8 of these serologically positive animals and inoculated into guinea pigs. Animals inoculated with 7 of the 8 milk specimens developed Q fever antibodies and fever, indicating that Q fever rickettsiae had been present in the milk and had established infection in the recipient guinea pigs. Three of the strains of Q fever recovered in this manner were further studied in the yolk sacs of embryonated eggs and in mice.

In a search for evidence of human infection a serologic survey for Q fever antibody was made on two groups of Wisconsin residents selected for occupational contact with livestock. The highest percentage (23.3) of serologic reactions to Q fever antigen was found in a small group of 30 consisting of farmers and their families who resided on and operated dairy farms where Q fever rickettsiae had been recovered from a few cows and positive serologic reactions had been demonstrated in a larger number. The fact that the serum titers of these individuals were relatively low (1:8 to 1:64) suggested past rather than recent Q fever infection.

In a group of 2,035 employees of a meat packing plant, 92 or 4.5 per cent were found

(Continued on page 224)

"Wake in our breast the living fires,
The Holy faith that warmed our sires. . . ."
OLIVER WENDELL HOLMES, M. D.

. . . gleanings from the Section on Medical History

The great-grandfather of Dr. Elizabeth Comstock, Arcadia, served as a lieutenant colonel in the Revolutionary War, receiving his commission on Gen. George Washington's recommendation.

Dr. Elizabeth Comstock

Historians say that at the Battle of Red Bank (New Jersey), Lt. Col. Adam Comstock saw his superior officer fall wounded. The young officer assumed command, and won the battle.

Later Adam Comstock was judge in the Court of Common Pleas, Saratoga County, New York. (At one time, it was said, he carried the politics of upstate New York in his coat-tail pocket).

Adam's grandson, Noah D. Comstock, was Dr. Comstock's father. He served as a Wisconsin assemblyman from 1872 to 1877 and in the state senate from 1883 to 1887.

Her uncle, Cyrus B. Comstock, was a West Point graduate and an engineer. He was senior aide-de-camp to Gen. U. S. Grant at the fall of Vicksburg.

Dr. Comstock's grandfather's brother, William, was a physician.

She was graduated from the Woman's Medical College of Pennsylvania in 1901, and so has practiced for 57 years, 35 of these in Wisconsin.

Dr. Comstock, a member of the State Medical Society for many years, is an active member of the Section on Medical History. Already she has made numerous contributions to the Section, many of which will find their way to the Medical Museum of Wisconsin, to be built in Prairie du Chien.

When she was initiated into the State Medical Society's 50 Year Club in 1951, she became the second member of her sex to join this exclusive group. The late Dr. Mina B. Glasier, of Bloomington, was the first.

Mrs. Walter Wiffler, La Crosse, recently sent the Section a number of official documents and a picture of her father, Dr. James Edmund Heraty, who had practiced in Fond du Lac, Bloomington, and La Crosse before his death last year. A member of the State Medical Society's "50 Year Club," Doctor Heraty, a native of Eden in Fond du Lac County, was graduated from the Marquette University School of Medicine in 1901. During World War I he was regimental surgeon at Camp Pike, Little Rock, Arkansas.

* * *

Dr. John G. Waddell, Madison, recently found a copy of Dr. John C. Gunn's "New Family Physician," a heavy tome with the subtitles, "Home Book of Health," and "Complete Household Guide." Published in 1866, the book was once owned by John Hill Winston of Evansville. Treatises on intemperance, influence of love, giddiness, midwifery, scrofula (king's evil), and hundreds of other subjects are included in the book. Dr. Waddell plans to look through an old barn on some family property in hopes of finding more items for the State Medical Society's Section on Medical History.

* * *

An interesting assortment of items was presented to the Section on Medical History by Mrs. Tompach of Racine. Her husband, Dr. Emil Tompach, died in 1939. The material includes pictures of the medical advisory board for Racine district, of a picnic of physicians of the area at Horlick's Dam, and one of the Racine City Physician Association. Mrs. Tompach also sent the doctor's Masonic membership card, a copy of a lecture given by Doctor Tompach on tuberculosis, letters from the assistant secretary of the Reconstruction Finance Corporation, Washington, and from former President Hoover's secretary, citations from the president and the World War I Selective Service System, and papers attesting to the physician's graduation from Rush Medical College in 1894 and his membership in the State Medical Society of Wisconsin.

the Wisconsin Medical Journal

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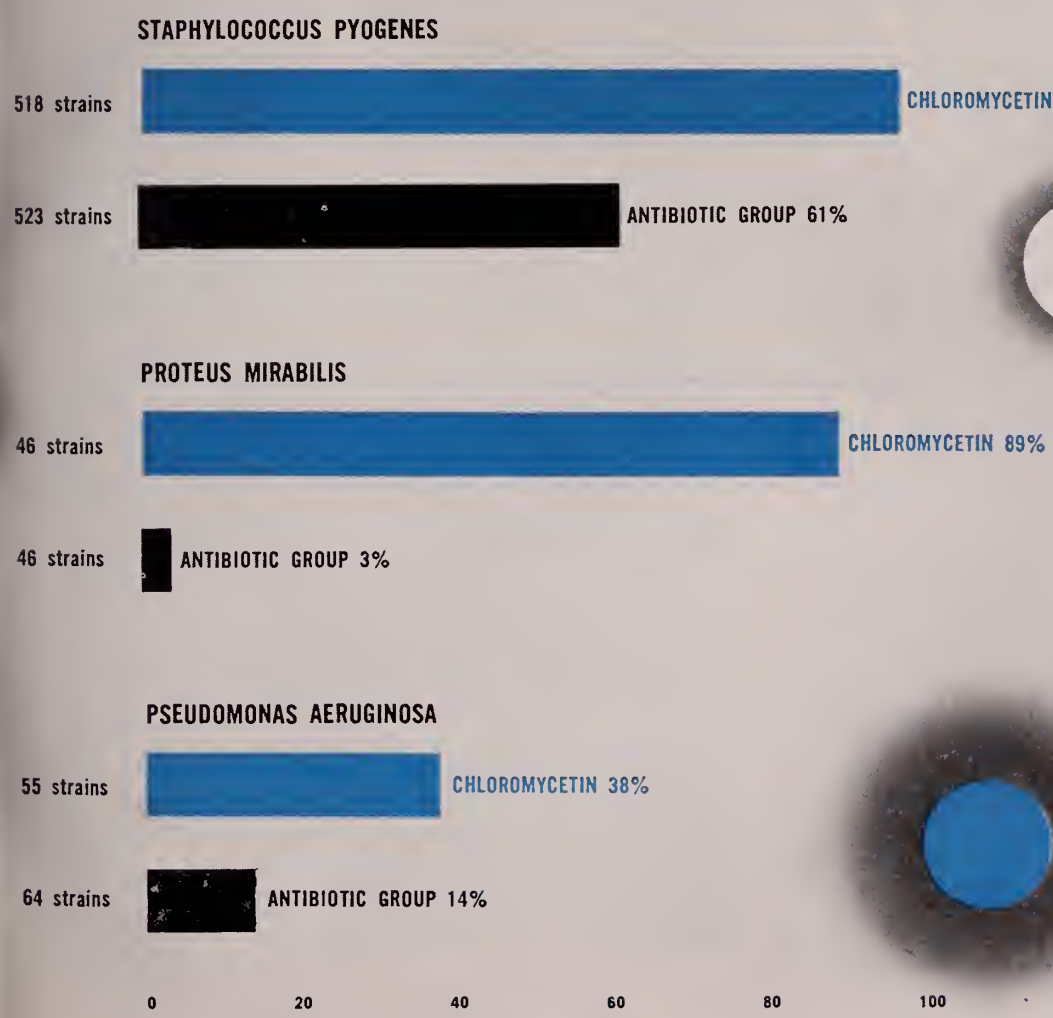

*Adapted from Roy, T. E.; Collins, A. M.; Craig, G., & Duncan, I. B. R.: *Canad. M.A.J.* 77:844 (Nov. 1) 1957.

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A MODERN PRIVATE SANITARIUM

for the Diagnosis, Care and Treatment of Nervous and Mental Disorders

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PRESCOTT, WISCONSIN

Located on beautiful Lake St. Croix, 18 miles from the Twin Cities, it has the advantages of both City and Country. Every facility for treatment provided, including recreational activities and occupational therapy under trained personnel. Close personal supervision given patients, and modern methods of therapy employed. Inspection and cooperation by reputable physicians invited. Rates very reasonable. Special rates given to terminal patients.

Prescott Office
Prescott, Wisconsin
Howard J. Laney, M.D.
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Consulting Neuro-Psychiatrists
Hewitt B. Hannah, M.D. : Andrew J. Leemhuis, M.D.
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release from pain and inflammation

with **BUFFERIN®**

IN ARTHRITIS

salicylate benefits with minimal salicylate drawbacks

Rapid and prolonged relief—with less intolerance. The analgesic and specific anti-inflammatory action of BUFFERIN helps reduce pain and joint edema—comfortably. BUFFERIN caused no gastric distress in 70 per cent of hospitalized arthritics with proved intolerance to aspirin. (Arthritics are at least 3 to 10 times as intolerant to straight aspirin as the general population.[1])

No sodium accumulation. Because BUFFERIN is sodium free, massive dosage for prolonged periods will not cause sodium accumulation or edema, even in cardiovascular cases.

Each *sodium-free* BUFFERIN tablet contains acetylsalicylic acid, 5 grains, and the antacids magnesium carbonate and aluminum glycinate.

Reference: 1. J.A.M.A. 158: 386 (June 4) 1955.

ANOTHER FINE PRODUCT OF BRISTOL-MYERS

Bristol-Myers Company
19 West 50 St., New York 20, N. Y

WHY SENSITIZE

in topical and ophthalmic infections

USE 'POLYSPORIN'®

brand

POLYMYXIN B—BACITRACIN OINTMENT

to insure broad-spectrum therapy with minimum allergenicity

For topical use: in ½ oz. and 1 oz. tubes.

For ophthalmic use: in ⅛ oz. tubes.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.

why wine in Diabetes?

To the physician faced with the treatment of diabetes, as well as to the diabetic sufferer on a necessarily restricted diet, it is reassuring that palatable dry table wines can be used safely to add a much needed sparkle and enjoyment to meals.

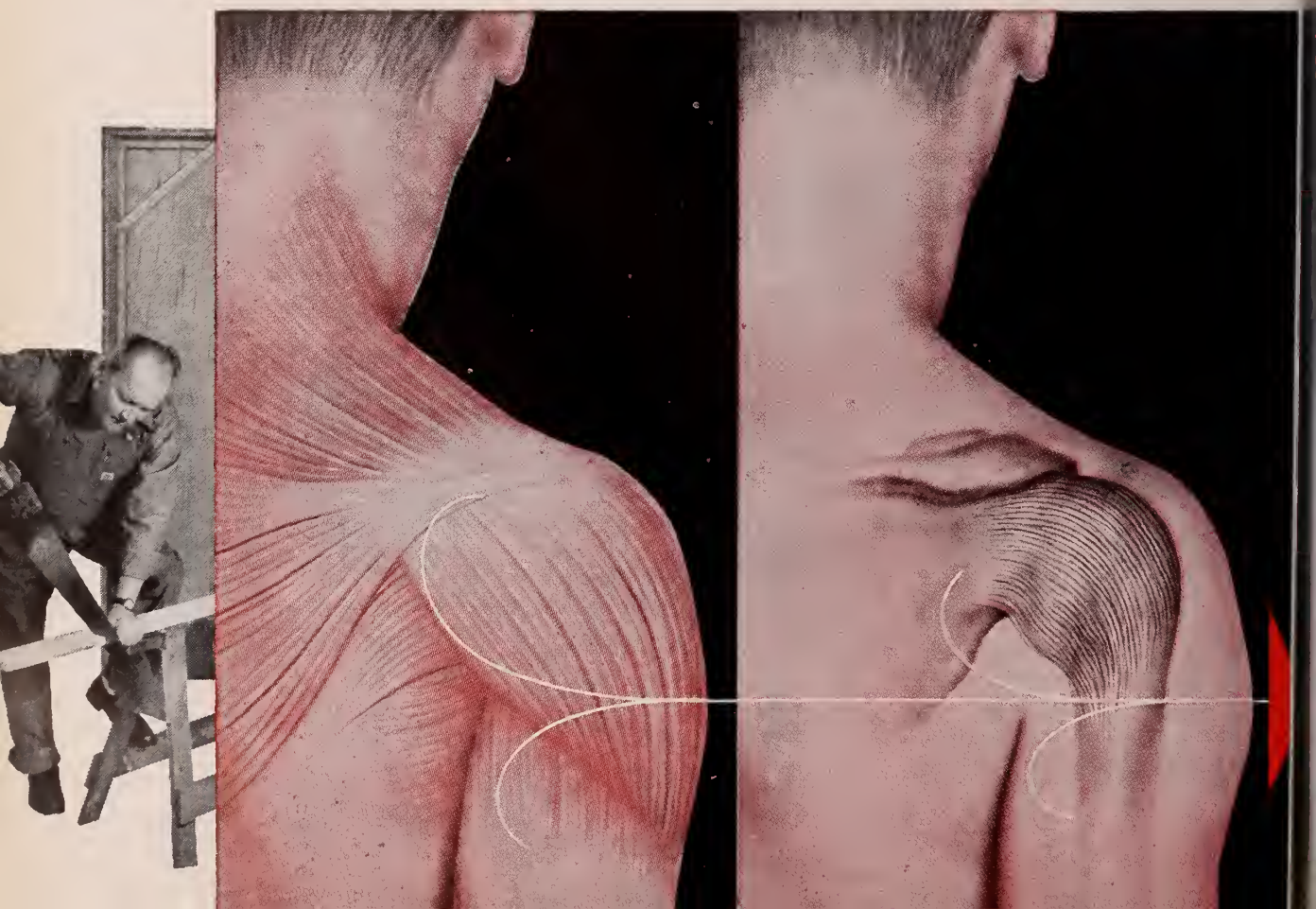
Wine can serve as an excellent and regular source of energy, which does not require the participation of insulin. Wine has a sparing action on fats and proteins, is not converted into glucose or fatty acids, and, therefore, is neither ketogenic nor anti-ketogenic.

Caloric Values of California Wines—Studies have shown that the average diabetic can oxidize from 7 to 10 cc. of alcohol per hour without producing any toxic or other undesirable symptoms.

Typical California table wines—except for sweet sauternes—yield from about 90 to 100 calories per 100 cc.; champagnes and other dry sparkling wines yield from 100 to 140 calories, while dry sherries, dry Vermouths and other miscellaneous wines will yield about 160 calories and up to 250 in case sweet Vermouth is used.

A table giving the composition and energy value of wines, suitable for the calculated diabetic diet, will be supplied on request.
You can make this request when writing for your copy of *"Uses of Wine in Medical Practice"* to Wine Advisory Board, 717 Market Street, San Francisco 3, California.

"Rheumatoid arthritis is a constitutional disease with symptoms affecting chiefly joints and muscles."[1] "Pain in the affected joint is accompanied by splinting of the adjacent muscles, with resultant 'muscle spasm.' "[2]



rheumatoid arthritis involves both joints and muscles only

MEPROLONE is the only anti-rheumatic-antiarthritic designed to relieve simultaneously (a) muscle spasm (b) joint-muscle inflammation (c) physical distress . . . and may thereby help prevent deformity and disability in more arthritic patients to a greater degree than ever before.

SUPPLIED: Multiple Compressed Tablets in bottles of 100, in three formulas:
MEPROLONE-5—5.0 mg. prednisolone, 400 mg. meprobamate and 200 mg. dried aluminum hydroxide gel.
MEPROLONE-2—2.0 mg. prednisolone, 200 mg. meprobamate and 200 mg. dried aluminum hydroxide gel.
MEPROLONE-1—supplies 1.0 mg. prednisolone in the same formula as MEPROLONE-2.

1. Comroe's Arthritis: Hollander, J. L., p. 149 (Fifth Edition, Lea & Febiger, Philadelphia, Pa. 1953).
2. Merck Manual: Lyght, C. E., p. 1102 (Ninth Edition, Merck & Co., Inc., Rahway, N. J. 1956).

MEPROLONE®

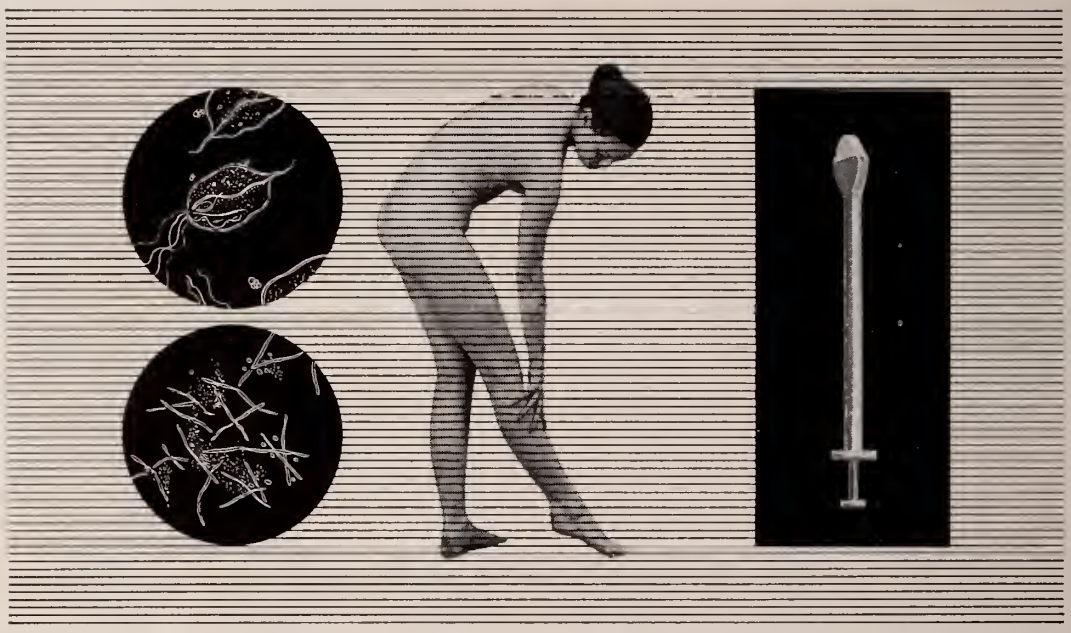
THE FIRST MEPROBAMATE PREDNISOLONE THERAPY

meprobamate to relieve muscle spasm
prednisolone to suppress inflammation

relieves both muscle spasm and joint inflammation

MSD MERCK SHARP & DOHME Philadelphia 1, Pa.
Division of MERCK & CO., INC.

FOR FLAGELLATE AND FUNGAL VAGINITIS



Floraquin®

Destroys Common Vaginal Pathogens; Rebuilds Normal Bacterial Barrier

Whenever a woman complains of vaginal discharge with pruritus, a trichomonal infection[1] must be suspected. Moniliasis, the second most frequent cause[2] of leukorrhea, often occurs[3] in conjunction with diabetes mellitus, pregnancy and estrogen or broad spectrum antibiotic therapy. Commonly used douches wash away normal acid secretions and protective Döderlein bacilli, thus tending to aggravate the problem.

Floraquin, containing Diodoquin® (diiodohydroxyquin, U.S.P.), eliminates infection and provides boric acid and sugar to restore the acidic pH which favors replacement of pathogens by normal Döderlein bacilli. The danger of recurrence is thus minimized.

Pitt reports[2] consistently good results after daily vaginal insufflation of Floraquin powder for three to five days, followed by acid douches and the daily insertion of Floraquin vaginal tablets throughout one or two menstrual cycles.

Intravaginal Applicator for Improved Treatment of Vaginitis—

This smooth, unbreakable, plastic plunger device is designed for simplified insertion of Floraquin tablets by the patient; it places tablets in the fornices and thus assures coating of the entire vaginal mucosa as the tablets disintegrate. A Floraquin applicator is supplied with each box of 50 tablets.

G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

1. Davis, C. H.: Trichomonas Vaginalis Infections: A Clinical and Experimental Study, J.A.M.A. *157:*126 (Jan. 8) 1955.
2. Pitt, M. B.: Leukorrhea, Causes and Management, J.M.A. Alabama *25:*182 (Feb.) 1956.
3. Lang, W. R.: Recent Advances in Vaginitis, Philadelphia Med. *51:*1494 (June 15) 1956.

SEARLE

"Most likely candidate for ORINASE"

age: 40+

insulin: 40−

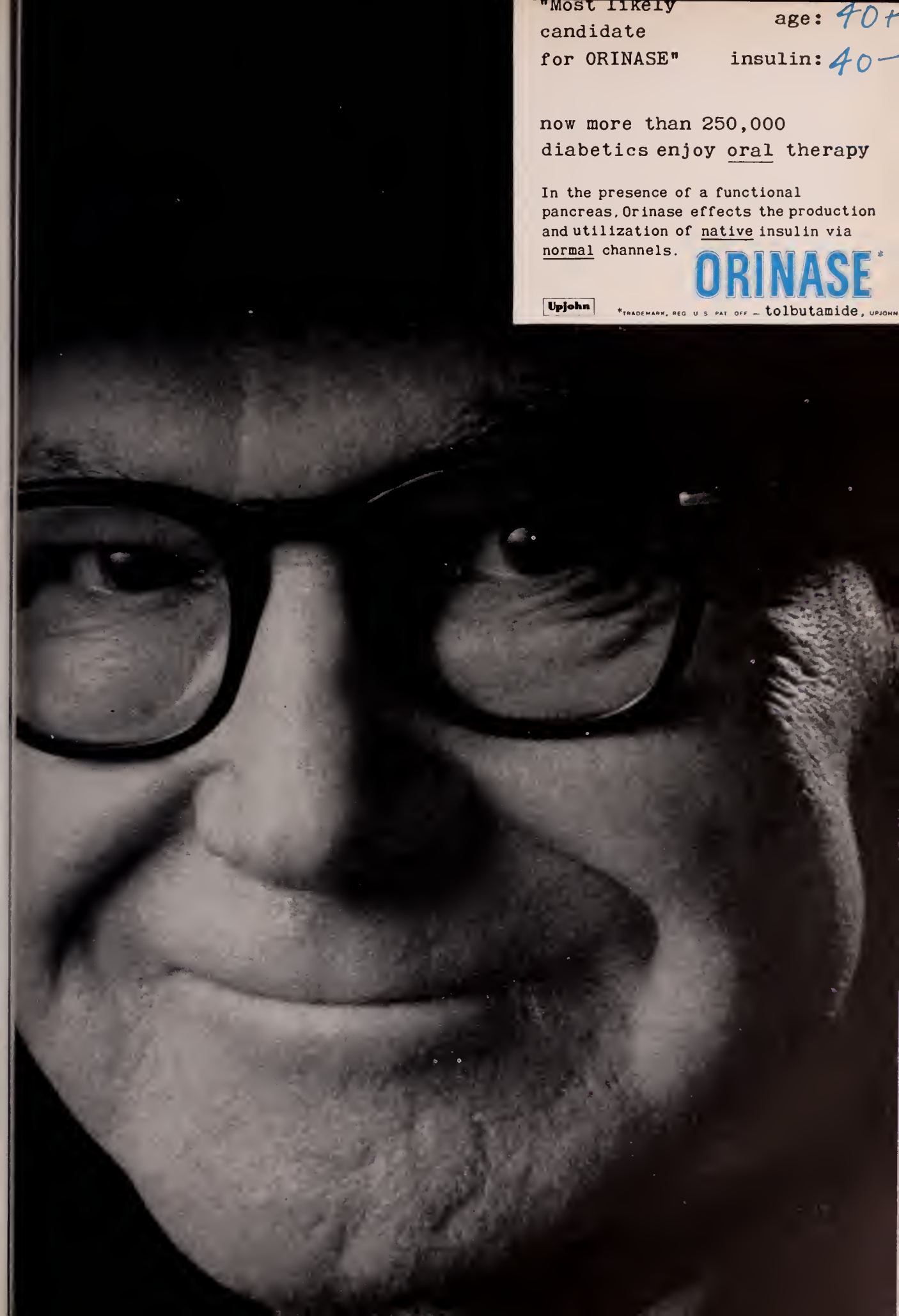
now more than 250,000 diabetics enjoy oral therapy

In the presence of a functional pancreas, Orinase effects the production and utilization of native insulin via normal channels.

ORINASE*

Upjohn

*TRADEMARK, REG U S PAT OFF — tolbutamide, UPJOHN



INDICATED:

NEO-MAGNACORT®

neomycin and hydrocortamate

TOPICAL OINTMENT

The first water-soluble dermatologic corticoid plus neomycin, for consistently outstanding control of contact dermatitis and other inflammatory dermatoses complicated by or threatened by infection.*

In 1/2-oz. and 1/6-oz. tubes, 0.5% neomycin sulfate and 0.5% hydrocortamate hydrochloride (hydrocortisone diethylaminoacetate hydrochloride) — MAGNACORT.

also available: MAGNACORT® Topical Ointment — in 1/2-oz. and 1/6-oz. tubes, 0.5% hydrocortamate hydrochloride (hydrocortisone diethylaminoacetate hydrochloride).

*Howell, C. M., Jr.: Am. Pract. & Digest Treat. 8:1928, 1957.

Pfizer

PFIZER LABORATORIES DIVISION, CHAS. PFIZER & CO., INC., BROOKLYN 6, NEW YORK

long day ahead
morning sun glare – eyes irritated
can't read – coach smoky
leave the work – let's lunch
back to work – eyes worse
take afternoon off – see doctor
pick up VISINE – home again
let's try the drops
nice dinner – read the paper
eyes comfortable – good TV play
use VISINE – bed 11:30
long day behind
turned out well **see the difference**

new VISINE* EYE DROPS

BRAND OF TETRAHYDROZOLINE HYDROCHLORIDE

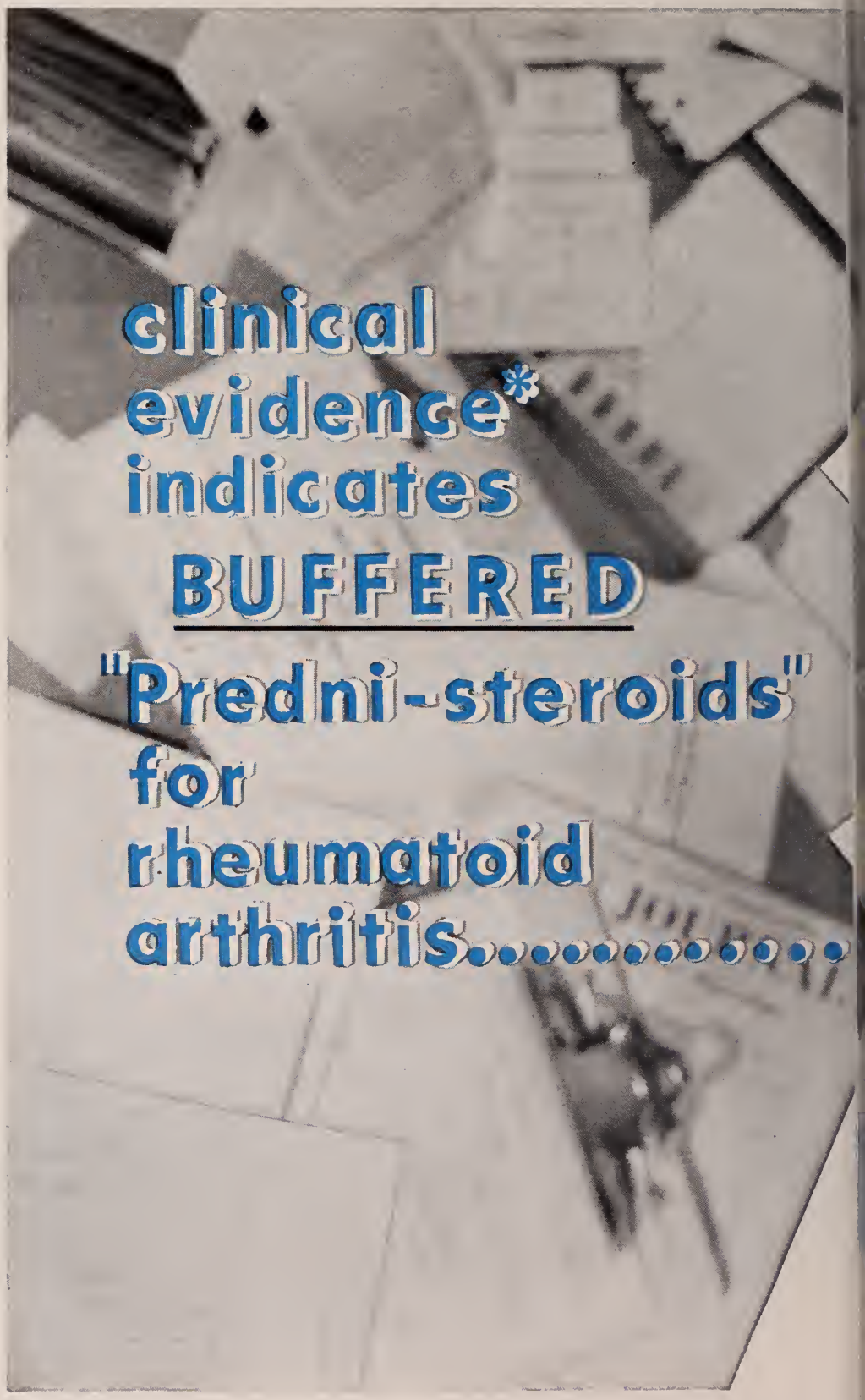
"an excellent ophthalmic decongestant . . ."[1]

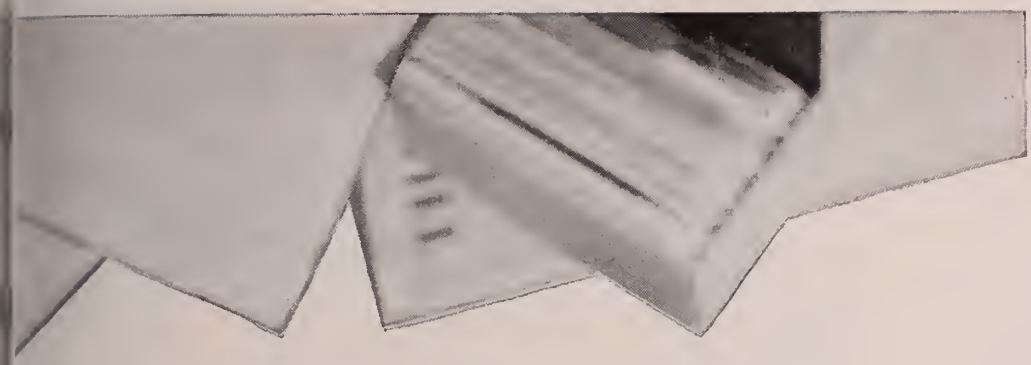
almost immediate relief of hyperemia, soreness, itching, burning, tearing — no rebound vasodilatation, mydriasis, photophobia or systemic effects. / *supplied: in 1/2 oz. bottles, 0.05% tetrahydrozoline hydrochloride in a solution containing sodium chloride, boric acid, sodium borate; with sterile eye dropper.*

*Trademark

1. Grossmann, E. E., and Lehman, R. H.: Am. J. Ophth. 42:121, 1956.

Pfizer PFIZER LABORATORIES *Division, Chas. Pfizer & Co., Inc. Brooklyn 6, New York*


clinical
evidence*
indicates
BUFFERED
"Predni-steroids"
for
rheumatoid
arthritis.....



Gastric distress accompanying "predni-steroid" therapy is a definite clinical problem — well documented in a growing body of literature.

n view of the beneficial re-
ses observed when antacids
land diets were used concom-
with prednisone and predni-
e, we feel that these measures
d be employed prophylacti-
to offset any gastrointestinal
ffects."—Dordick, J. R. *et al.*:
State J. Med. 57:2049 (June
957.

*"It is our growing conviction that all patients receiving oral steroids should take each dose after food or with adequate buffering with aluminum or magnesium hydroxide preparations."—Sigler, J. W. and Ensign, D. C.: J. Kentucky State M. A. 54:771 (Sept.) 1956.

*"The apparent high incidence of this serious [gastric] side effect in patients receiving prednisone or prednisolone suggests the advisability of routine co-administration of an aluminum hydroxide gel."—Bollet, A. J. and Bunim, J. J.: J. A. M. A. 158:459 (June 11) 1955.

One way to make sure that patients receive full benefits of "predni-steroid" therapy plus positive protection against gastric distress is by prescribing CO-DELTRA or CO-HYDELTRA.

Co-Deltra®
PREDNISONE BUFFERED

ultiple compressed tablets

provide all the benefits of "Predni-steroid" therapy— plus positive antacid protection against gastric distress

Co-Hydeltra®
PREDNISOLONE BUFFERED

2.5 mg. or 5.0 mg. of prednisone or prednisolone, plus 300 mg. of dried aluminum hydroxide gel and 50 mg. magnesium trisilicate, in bottles of 30, 100, 500.

MERCK SHARP & DOHME Division of MERCK & CO., INC., Philadelphia 1, Pa. MSD

For more certain control of

virtually **ALL**

DIARRHEAS

DONNAGEL

Robins

WITH

NEOMYCIN

ANTIBIOTIC • ADSORBENT • DEMULCENT • ANTISPASMODIC

Diarrheas due to neomycin-susceptible pathogens are effectively treated by the highly efficient intestinal antibiotic in DONNAGEL WITH NEOMYCIN, whose other ingredients serve to control toxic, irritative and emotional causes. *Result:* Early reestablishment of normal bowel function.

SUPPLY: Bottles of 6 fl. oz.

ALSO AVAILABLE: DONNAGEL, the original formula, for use when the antibiotic component is not indicated. Bottles of 6 fl. oz.

Each 30 cc. (1 fl. oz.) of the comprehensive formula of DONNAGEL WITH NEOMYCIN contains:

Neomycin sulfate (Equal to neomycin base, 210 mg.)	300 mg.
Kaolin (90 gr.)	6.0 Gm.
Pectin (2 gr.)	142.8 mg.
Dihydroxyaluminum aminoacetate	0.25 Gm.
Hyoscyamine sulfate	0.1037 mg.
Atropine sulfate	0.0194 mg.
Hyoscine hydrobromide	0.0065 mg.
Phenobarbital (¼ gr.)	16.2 mg.

A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA

Ethical Pharmaceuticals of Merit since 1878

The non-narcotic analgesic with the potency of codeine

DARVON (Dextro Propoxyphene Hydrochloride, Lilly) is equally as potent as codeine yet is much better tolerated. Side-effects, such as nausea or constipation, are minimal. You will find 'Darvon' helpful in any condition associated with pain. The usual adult dose is 32 mg. every four hours or 65 mg. every six hours as needed. Available in 32 and 65-mg. pulvules.

DARVON COMPOUND (Dextro Propoxyphene and Acetylsalicylic Acid Compound, Lilly) combines the antipyretic and anti-inflammatory benefits of 'A.S.A. Compound'* with the analgesic properties of 'Darvon.' Thus, it is useful in relieving pain associated with recurrent or chronic disease, such as neuralgia, neuritis, or arthritis, as well as acute pain of traumatic origin. The usual adult dose is 1 or 2 pulvules every six hours as needed.

Each Pulvule 'Darvon Compound' provides:

'Darvon'	*32 mg.*
Acetophenetidin	*162 mg.*
'A.S.A.' (Acetylsalicylic Acid, Lilly)	*227 mg.*
Caffeine	*32.4 mg.*

*'A.S.A. Compound' (Acetylsalicylic Acid and Acetophenetidin Compound, Lilly)

Lilly POLIO VACCINE

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.

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NOW...A NEW TREATMENT

'CARDILATE'*

for THE PROPHYLAXIS OF ANGINA PECTORIS

'Cardilate' tablets shaped for easy retention in the buccal pouch

"... the degree of increase in exercise tolerance which sublingual erythrol tetranitrate permits, approximates that of nitroglycerin, amyl nitrite and octyl nitrite more closely than does any other of the approximately 100 preparations tested to date in this laboratory."

"Furthermore, the duration of this beneficial action is prolonged sufficiently to make this method of treatment of practical clinical value."

Riseman, J. E. F., Altman, G. E., and Koretsky, S.: Nitroglycerin and Other Nitrites in the Treatment of Angina Pectoris, Circulation (Jan.) 1958.

* 'Cardilate' brand Erythrol Tetranitrate SUBLINGUAL TABLETS, 15 mg. scored

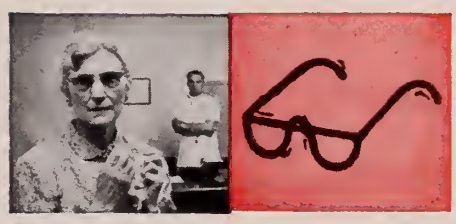
BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York

in each of these indications for a tranquilizer...

SR is a cardiac patient. His doctor put him on ATARAX because (+) it is an anti-arrhythmic and non-hypotensive tranquilizer.

Other tranquilizers added to PN's g. i. discomfort (he has ulcers). But now his doctor has him on ATARAX because (+) it lowers gastric secretion while it tranquilizes.

Asthmatic JL used to have frequent tantrums followed by acute bronchospasm. Her family doctor tranquilized her with ATARAX because (+) it is safe, even for children.



Senile anxiety and persecution complex dogged Mrs. K. until her doctor prescribed ATARAX Syrup. (+) It tastes good, and it's a perfect vehicle for Mrs. K's tonic.

Dosage: Children, 1-2 *10 mg.* tablets or 1-2 tsp. Syrup t.i.d. Adults, one *25 mg.* tablet or 1 tbsp. Syrup q.i.d.

Supplied: 10, 25 and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

...ATARAX® (BRAND OF HYDROXYZINE) gives you an extra benefit

ROERIG

New York 17, New York
Division, Chas. Pfizer & Co., Inc.

FIRST—clinically confirmed for better management of psychotic patients

NOW—clinically confirmed as an improved antiemetic agent

VESPRIN

Squibb Trifluprom azine

PROMPT, POTENT and LONG-LASTING **ANTIEMETIC ACTIVITY**

Clinical investigators report that in clinical studies*

Post-operatively	After Nitrogen Mustard Therapy	In Chronic Nausea and Vomiting	In Infections, Intra-abdominal Disease, and Carcinomatosis	In Neurosurgical Diagnostic Procedures	In Pregnancy When Vomiting is Persistent

VESPRIN

- showed potent antiemetic action
- completely relieved nausea and vomiting in small intravenous doses
- showed a prolonged antiemetic effect
- caused little or no pain at injection site
- controlled chronic nausea and vomiting in orally administered doses
- produced relief in certain cases refractory to other antiemetics
- often markedly depressed or abolished the gag reflex
- effectively terminated the hard-to-control nausea and vomiting common to nitrogen mustard therapy
- provided prophylaxis against the nausea and vomiting associated with pneumoencephalography

*Reports to the Squibb Institute for Medical Research

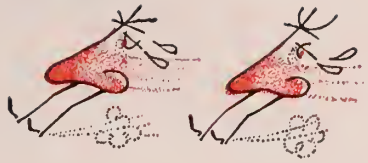
antiemetic dosage: *Intravenous route*—8 mg. average single dose; dosage range 5 to 10 mg.
Intramuscular route—15 mg. average single dose; dosage range 5 to 15 mg.
Oral route—10 to 20 mg. initially, subsequently 10 mg. t.i.d.

supply: *Parenteral Solution*—1 cc. ampuls (20 mg./cc.)
Oral Tablets—10 mg., 25 mg., 50 mg., in bottles of 50 and 500

SQUIBB *Squibb Quality—the Priceless Ingredient*

*VESPRIN IS A SQUIBB TRADEMARK

running noses . . .



caused by pollen allergies

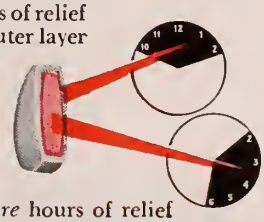
TRIAMINIC stops rhinorrhea, congestion and other distressing symptoms of summer allergies, including hay fever. Running nose, watery eyes and sneezing are best relieved by antihistamine *plus* decongestant action — systemically — with TRIAMINIC.

This new approach frequently succeeds where less complete therapy has failed. It is not enough merely to use histamine antagonists; ideally, therapy must be aimed also at the congestion of the nasal mucosa. Triaminic provides such effective combined therapy in a single timed-release tablet.

TRIAMINIC brings relief in minutes—lasts for hours. Running noses stop, congested noses open—and stay open for 6 to 8 hours.

Triaminic provides around-the-clock freedom from allergic congestion with just one tablet t.i.d. because of the special timed-release design.

first—3 to 4 hours of relief from the outer layer



then—3 to 4 *more* hours of relief from the inner core

Dosage: One tablet in the morning, mid-afternoon and at bedtime. In postnasal drip, one tablet at bedtime is usually sufficient.

Each timed-release TRIAMINIC Tablet contains:

Phenylpropanolamine HCl	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

TRIAMINIC FOR THE PEDIATRIC PATIENT

TRIAMINIC Juvelets*, providing easy-to-swallow half-dosages for the 6- to 12-year-old child, with the timed-release construction for prolonged relief.

*Trademark.

TRIAMINIC Syrup, for those children and adults who prefer a liquid medication. Each 5 ml. teaspoonful is equivalent to ¼ Triaminic Tablet or ½ Triaminic Juvelet.

Triaminic®

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska • Peterborough, Canada

Investigator

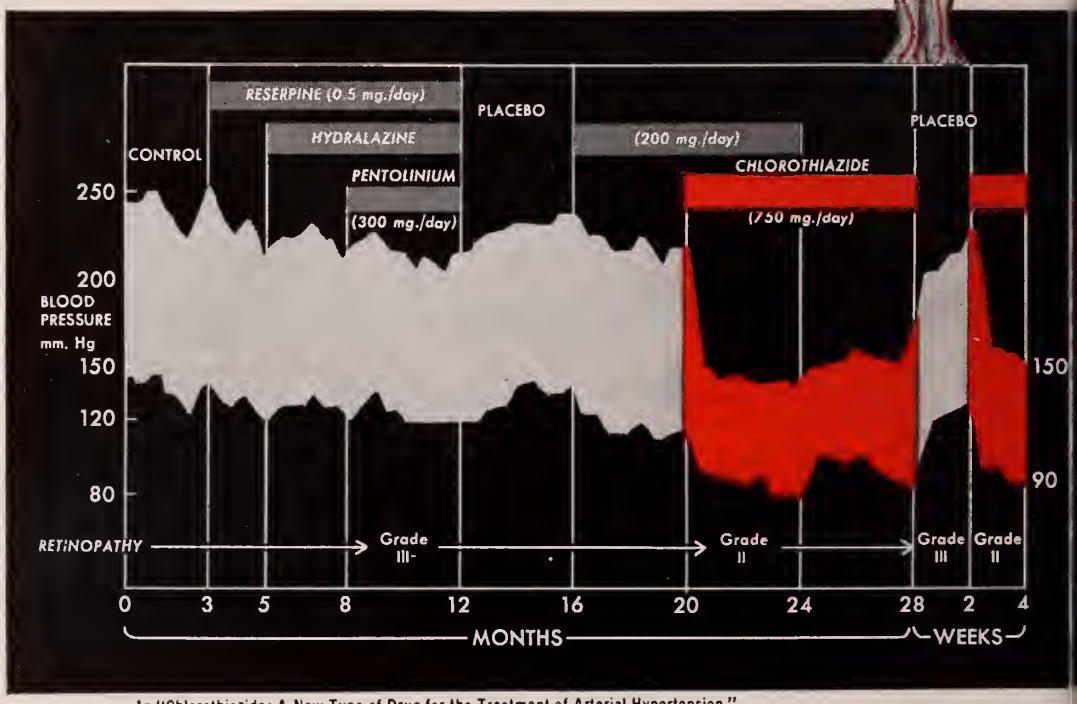
after investigator report

Wilkins, R. W.: New England J. Med. **257**:1026, Nov. 21, 1957.

"Chlorothiazide added to other antihypertensive drugs reduced the blood pressure in 19 of 23 hypertensive patients." "All of 11 hypertension subjects in whom splanchnicectomy had been performed had a striking blood pressure response to oral administration of chlorothiazide." ". . . it is not hypotensive in normotensive patients with congestive heart failure, in whom it is markedly diuretic; it is hypotensive in both compensated and decompensated hypertensive patients (in the former without congestive heart failure, it is not markedly diuretic, whereas in the latter in congestive heart failure, it is markedly diuretic). . . ."

Freis, E. D., Wanko, A., Wilson, I. H. and Parrish, A. E.: J.A.M.A. **166**:137, Jan. 11, 1958.

"Chlorothiazide (maintenance dose, 0.5 Gm. twice daily) added to the regimen of 73 ambulatory hypertensive patients who were receiving other antihypertensive drugs as well caused an additional reduction [16%] of blood pressure." "The advantages of chlorothiazide were (1) significant antihypertensive effect in a high percentage of patients, particularly when combined with other agents, (2) absence of significant side effects or toxicity in the dosages used, (3) absence of tolerance (at least thus far), and (4) effectiveness with simple 'rule of thumb' oral dosage schedules."



In "Chlorothiazide: A New Type of Drug for the Treatment of Arterial Hypertension," Hollander, W. and Wilkins, R. W.: Boston Med. Quart. **8**: 1, September, 1957.

MERCK SHARP & DOHME Division of MERCK & CO., Inc., Philadelphia 1, Pa.

ıe effectiveness of 'DIURIL'

(CHLOROTHIAZIDE)

in

Hypertension

as simple as 1-2-3

1 **INITIATE THERAPY WITH 'DIURIL'.** 'DIURIL' is given in a dosage range of from 250 mg. twice a day to 500 mg. three times a day.

2 **ADJUST DOSAGE OF OTHER AGENTS.** The dosage of other antihypertensive medication (reserpine, veratrum, hydralazine, etc.) is adjusted as indicated by patient response. If the patient is established on a ganglionic blocking agent (e.g., 'INVERSINE') this should be continued, but the total daily dose should be immediately reduced by as much as 25 to 50 per cent. This will reduce the serious side effects often observed with ganglionic blockade.

3 **ADJUST DOSAGE OF ALL MEDICATION.** The patient must be frequently observed and careful adjustment of all agents should be made to determine optimal maintenance dosage.

SUPPLIED: 250 mg. and 500 mg. scored tablets 'DIURIL' (chlorothiazide); bottles of 100 and 1,000.

'DIURIL' is a trade-mark of Merck & Co., Inc.

Smooth, more trouble-free management of hypertension with 'DIURIL'

premenstrual tension

responds very well to Compazine*

- agitation and apprehension are promptly relieved
- emotional stability is considerably improved
- nervous tension and fatigue are greatly reduced
- appetite and sleep patterns improve
- depression often disappears

For prophylaxis: 'Compazine' Spansule† capsules provide all-day or all-night relief of anxiety with a single oral dose. *Also available:* Tablets, Ampuls, Multiple dose vials, Syrup and Suppositories.

Smith Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off. for prochlorperazine, S.K.F.
†T.M. Reg. U.S. Pat. Off. for sustained release capsules, S.K.F.

with new

CARTRAX*

PETN + ATARAX®

(PENTAERYTHRITOL TETRANITRATE) (BRAND OF HYDROXYZINE)

why PETN? *For cardiac effect:* PETN is ". . . the most effective drug currently available for prolonged prophylactic treatment of angina pectoris."[1] Prevents about 80% of anginal attacks.

why ATARAX? *For ataractic effect:* One of the most effective—and probably the safest—of tranquilizers, ATARAX frees the angina patient of his constant tension and anxiety. Ideal for the on-the-job patient. And ATARAX has a unique advantage in cardiac therapy: it is anti-arrhythmic and non-hypotensive.

why combine the two? *For greater therapeutic success:* In clinical trials, CARTRAX was demonstrably superior to previous therapy, including PETN alone. Specifically, 87% of angina patients did better. They were shown to suffer fewer attacks . . . require less nitroglycerin . . . have increased tolerance to physical effort . . . and be freed of cardiac fixation.

1. Russek, H. I.: Postgrad. Med. *19*:562 (June) 1956.

Dosage and Supplied: Begin with 1 to 2 yellow CARTRAX "10" tablets (10 mg. PETN plus 10 mg. ATARAX) 3 to 4 times daily. When indicated this may be increased by switching to pink CARTRAX "20" tablets (20 mg. PETN plus 10 mg. ATARAX.) For convenience, write "CARTRAX 10" or "CARTRAX 20." In bottles of 100.

CARTRAX should be taken 30 to 60 minutes *before* meals, on a continuous dosage schedule. Use PETN preparations with caution in glaucoma.

Rx OERIG

NEW YORK 17, NEW YORK
Division, Chas. Pfizer & Co., Inc.

*Trademark

AN AMES CLINIQUICK

CLINICAL BRIEFS FOR MODERN PRACTICE

*Adapted from Wright, S.: Applied Physiology, ed. 8, London, Oxford University Press, 1947, p. 734.

What's wrong with the term "emptying of the gallbladder"?

The gallbladder discharges bile by fractional evacuation. It is not emptied completely at any one time even following a fatty meal.

Source—Lichtman, S. S.: Diseases of the Liver, Gallbladder and Bile Ducts, ed. 3, Philadelphia, Lea & Febiger, 1953, vol. 2, p. 1177.

routine physiologic support for "sluggish" older patients

DECHOLIN® one tablet t.i.d.
therapeutic bile

increases bile flow and gallbladder function—combats bile stasis and concentration... helps thin gallbladder contents.

corrects constipation without catharsis—prevents colonic dehydration and hard stools... provides effective physiologic stimulant.

DECHOLIN tablets (dehydrocholic acid, AMES) 3¾ gr. Bottles of 100 and 500.

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relieves allergy all day or all night

The unretouched X-ray films show how Lontabs release medication in the digestive tract. So that the prolonged erosion of the Lontab core could be visualized by X-ray, subject was given 10 Lontabs, each containing 100 mg. of a radiopaque substance in place of Pyribenzamine.

With its unique formulation, the Pyribenzamine Lontab not only relieves allergy symptoms promptly, but sustains relief as long as 12 hours.

Special outer shell releases 33 mg. Pyribenzamine hydrochloride within 10 minutes.

Unique core releases approximately 18 mg. Pyribenzamine hydrochloride the 1st hour, approximately 50 mg. from the 2nd to the 12th hour.

SUPPLIED: Pyribenzamine *Lontabs* — full-strength — 100 mg. (light blue).

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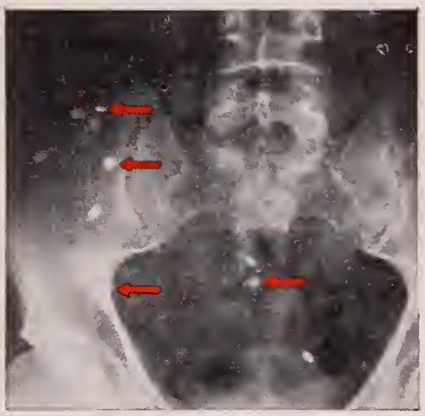
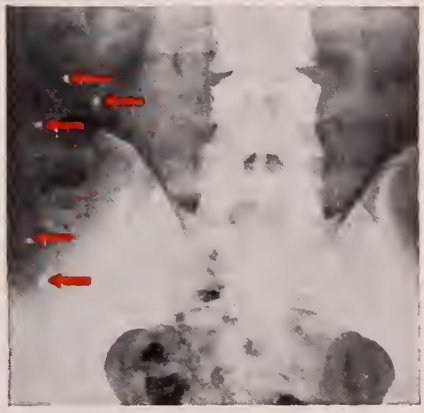
C I B A SUMMIT, N. J.

2 hours Lontabs are in the stomach and small bowel. Release of core substance is well under way.

4 hours Lontabs are in the ileum and cecum as core has steadily eroded.



8 hours Lontabs are still visible as substance of core continues to be released.



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New Control Over Sulfonamide-sensitive Organisms. KYNEX maintains the prolonged, high tissue concentrations of primary importance in treatment of urinary infections . . . a therapeutic asset toward preventing manifest pyelonephritis as a complication of persistent bacteriuria during pregnancy and puerperium. Maintenance of sterile urine in such patients was accomplished with 1 tablet of KYNEX daily.[3]

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Sulfamethoxypyridazine Lederle

Dosage: The recommended adult dose is 1 Gm. (2 tablets) the first day, followed by 0.5 Gm. (1 tablet) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours. Dosage in children, according to weight; i.e., a 40 lb. child should receive ¼ of the adult dosage. It is recommended that these dosages not be exceeded.

KYNEX—WHEREVER SULFA THERAPY IS INDICATED

Tablets: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

Syrup: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

References: 1. Grieble, H. C. and Jackson, G. G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958. 2. Editorial *New England J. Med.* 258:48-49,1958. 3. Jones, W. F., Jr. and Finland, M., Sulfamethoxypyridazine and Sulfachloropyridazine. *Ann. New York Acad. Sc.* 60:473-483, 1957.

*Reg. U. S. Pat. Off.

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'DIURIL'

(CHLOROTHIAZIDE)

FORD, R. V., Rochelle, J.B.III, Handley, C. A., Moyer, J. H. and Spurr, C. L.: J.A.M.A. **166**:129, Jan. 11, 1958.

". . . in premenstrual edema, convenience of therapy points to the selection of chlorothiazide, since it is both potent and free from adverse electrolyte actions." In the vast majority of patients, 'DIURIL' relieves or prevents the fluid "build-up" of the premenstrual syndrome. The onset of relief often occurs within two hours following convenient, oral, once-a-day dosage. 'DIURIL' is well tolerated, does not interfere with hormonal balance and is continuously effective—even on continued daily administration.

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SUPPLIED: 250 mg. and 500 mg. scored tablets 'DIURIL' (chlorothiazide); bottles of 100 and 1,000.

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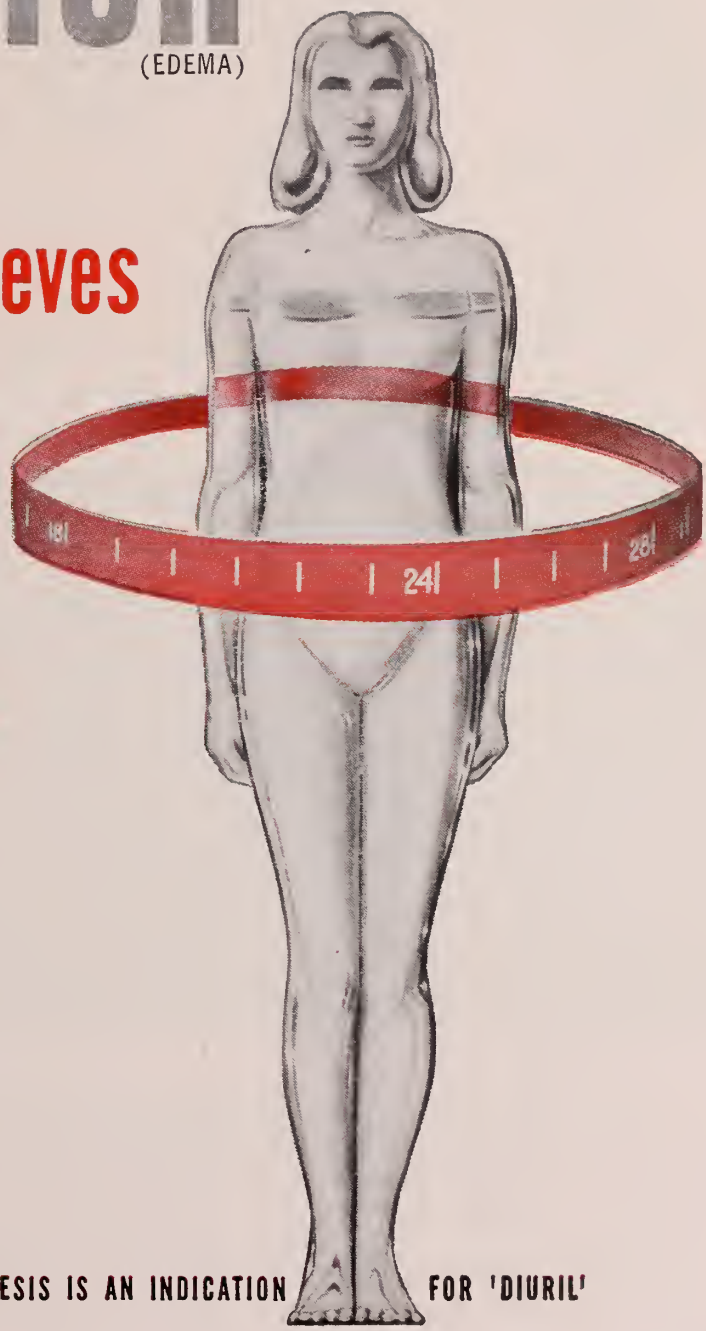

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(Theominal with Rauwolfia serpentina)

FOR ESSENTIAL HYPERTENSION

RAUWOLFIA SERPENTINA—used medicinally for centuries in India and Malaya

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ADVANTAGES:

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Dose: 1 tablet two or three times daily.

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INTRAMUSCULAR IRON-DEXTRAN COMPLEX

CHRONIC BLOOD LOSS:

"...this patient did not receive any transfusion of blood or any hematinic other than the intramuscular dose of iron. His initial concentration of hemoglobin measured 5.8 gm. per 100 cc. of blood and in spite of operation [hemorrhoidectomy] and further loss of blood the concentration increased to 12.2 gm. within less than 3 weeks. Concomitantly with the hematologic improvement there was clinical improvement and subsidence of the initial primary symptoms [unusual fatigability, dyspnea, palpitation on exertion]."[1]

INTOLERANCE TO ORAL IRON:

"...she had an excellent response with a reticulocyte peak of 5.3 per cent on the seventh day, and a complete disappearance of the anemia and conversion from hypochromic to normochromic cells by the end of two months. She experienced remarkable improvement in pep and sense of well-being coincident with the alleviation of her anemia."[2]

(1) Hagedorn, A. B.: Proc. Staff Meet. Mayo Clin. 32:705 (Dec. 11) 1957.
(2) Best, W. R.; Louis, J., and Limarzi, L. R.: M. Clin. North America (Jan.) 1958, p. 3.

Supplied: 2-cc. and 5-cc. ampuls, boxes of 4. Physician's directions in every box. There are 50 mg. of elemental iron per cc. Request brochure NDA 17, Imferon.

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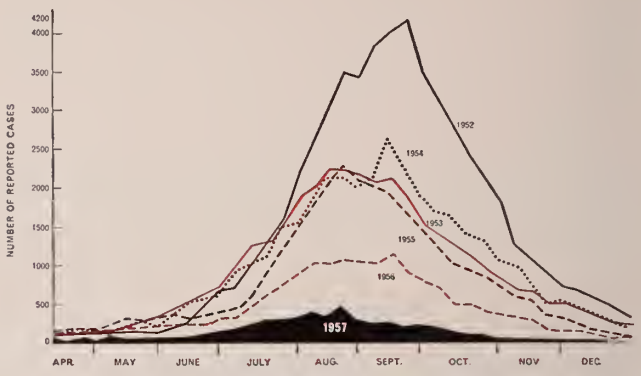
A MIRACLE IN OUR TIME ?

At the last accounting,[1] physicians throughout the country had administered at least one dose of poliomyelitis vaccine to 64 million Americans—all three doses to an estimated 34 million. Undoubtedly, these inoculations have played a major part in the dramatic reduction of paralytic poliomyelitis in this country.



Incidence of polio in the United States, 1952-1957
(data compiled from U.S.P.H.S. reports)

vaccine is plentiful for the job remaining

There are still more than 45 million Americans under forty who have received no vaccine at all and many more who have taken only one or two doses.

As it was phrased in a public statement by the Department of Health, Education, and Welfare:

> *"It will be a tragedy if, simply because of public apathy, vaccine which might prevent paralysis or even death lies on the shelf unused."*[2]

Eli Lilly and Company is prepared to assist you and your local medical society to reach those individuals who still lack full protection. *For information see your Lilly representative.*

1. *J. A. M. A.*, 165:21 (*November 23*), *1957*.
2. *Department of Health, Education, and Welfare: News Release, October 10, 1957.*

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NILEVAR® restores positive nitrogen balance

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When loss of nitrogen delays postsurgical recovery or stalls convalescence after acute illness and in severe burns and trauma, Nilevar has been found to effect these responses:

- **Appetite improves**
- **Weight increases**
- **The patient feels better**
- **The patient recovers faster**

Similarly Nilevar helps correct the "protein catabolic state" associated with prolonged bed rest in carcinomatosis, tuberculosis, anorexia nervosa and other chronic wasting diseases.

Nilevar is unique among anabolic steroids in that androgenic side action is minimal or absent in appropriate dosage.

Nilevar (brand of norethandrolone) is supplied as tablets of 10 mg. and ampuls (1 cc.) of 25 mg. The dosage of both forms is from 10 to 50 mg. daily.

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"Wake in our breast the living fires,
The Holy faith that warmed our sires. . . ."
OLIVER WENDELL HOLMES, M. D.

. . . gleanings from the Section on Medical History

Back in 1905, payment of $10 would purchase a "ticket" entitling the holder to medicine, admission, medical and surgical treatment in Dr. Michael Ravn's Hospital at Merrill for one full year. This covered treatment and hospitalization for wounds, injuries or sickness, except insanity, chronic and contagious diseases.

The "ticket" said the wounds, injuries or sickness "hereafter contracted," would have to disable its holder from the performance of manual labor before he could collect. Other provisions:

"Venereal diseases treated on this ticket at this hospital only. Free baths: Turkish, Russian, plunge and shower. When badly injured or sick, telegraph ahead, and ambulance will meet you at the train. When ordering medicine, which is sent free to any part of the country, write plainly the number of this certificate, name, post office and express office address. If not received promptly, notify us at once."

Dr. Ravn's tickets had exchange privileges with hospitals in Duluth; Bismarck, N. D.; Denver; Tacoma; Chicago; Jamestown, N. D.; and the Alexian Brothers' Hospital, Oshkosh, and Marinette and Menomonie Hospital in Marinette.

Oldtimers may recall that Dr. Ravn's hospital had been converted from an old mansion in Merrill and had a staff of six nurses. It also had a hitching post for horses where the sidewalk met the street.

* * *

On Oct. 5, 1918, Dr. Stephen E. Gavin, Fond du Lac, was named to a board of officers at Camp Colt, Gettysburg, Pa., to examine candidates for appointment as chaplains in the United States Army. At that time, Dr. Gavin was a captain.

On Nov. 5, 1918, Dr. Gavin was appointed camp surgeon. He became a major.

Camp Colt was a tank corps training base in World War One. It was not reactivated in World War Two.

Dr. Michael Ravn's Hospital

Both of Dr. Gavin's appointments were signed by a young army man holding his first major command. He was Dwight D. Eisenhower.

In October he signed the Special Order 196 as a major; a month later (Special Order 227), he signed it as a lieutenant colonel.

* * *

An interesting assortment of items was presented to the Section on Medical History by Mrs. Tompach of Racine. Her husband, Dr. Emil Tompach, died in 1939. The material includes pictures of the medical advisory board for the Racine district, of a picnic of physicians of the area at Horlick's Dam and one of the Racine City Physician Association. Mrs. Tompach also sent along the doctor's Masonic membership card, a copy of a lecture given by Dr. Tompach on tuberculosis, letters from the assistant secretary of the Reconstruction Finance Corp., Washington; from former President Hoover's secretary; citations from the president of the United States and the World War I Selective Service System, and papers attesting to his graduation from Rush Medical College in 1894 and membership in the State Medical Society.

CORRESPONDENCE

May 13, 1958

State Medical Society
Madison, Wisconsin

Dear Sirs:

Our 4–H Club, Willing Workers of Fond du Lac county, wish to thank the State Medical Society of Wisconsin for their gift of a subscription to Today's Health. This recognition for our work in the health-safety program will give encouragement to the club members and spur them on to an even better program this year. Thank you again.

Yours truly,

MRS. WALTER W. WILSIE
General Leader
Brandon, Wisconsin

* * *

April 21, 1958

Dear Editor:

The recent report of the Ad Hoc Committee of the Surgeon General of the United States, after weighing the advantages and disadvantages of BCG vaccination, states: "It is believed, however, that the advantages of vaccination outweigh the disadvantages for tuberculin negative persons who are exposed to a definite risk of infection, especially if they cannot be retested frequently with tuberculin."

This Committee recommended BCG vaccination for those groups recommended by the American Trudeau Soceity, the American College of Chest Physicians, the American Medical Association, and the Medical Advisory Committee of Research Foundation.

The specific groups recommended for BCG vaccination by the American Trudeau Society are:

1. Doctors, medical students, and nurses who are exposed to tuberculosis.
2. All hospital and laboratory personnel whose work exposes them to contact with the bacillus of tuberculosis.
3. Individuals who are unavoidably exposed to infectious tuberculosis in the home.
4. Patients and employees in mental hospitals, prisons, and other custodial institutions in whom the incidence of tuberculosis mortality rate is unusually high.
5. Children and certain adults considered to have inferior resistance and living in communities in which the tuberculosis mortality rate is unusually high.

There have been numerous inquiries from all parts of the United States as to where BCG vaccine may be obtained. In order to assist those interested, the following information is offered:

BCG vaccine may be obtained by any licensed physician in the United States and its territories by writing to the laboratories of Research Foundation and the University of Illinois, the only institutions licensed to produce and distribute BCG in this country. The address of Research Foundation is: 70 West Hubbard Street, Chicago 10, Illinois.

SOL ROY ROSENTHAL, M.D., Ph.D.,
Medical Director, Research Foundation, and Director, Institution for TB Research,
University of Illinois

MEDICAL LECTURE TOUR TO ASIA

The Asia–Pacific Academy of Ophthalmology is sponsoring a good will tour to countries of the Orient following the International Congress of Ophthalmology in Brussels in September, 1958. The purpose of this tour, which is to last approximately one month, is to hold joint meetings with ophthalmologists in Pakistan, India, Thailand, the Philippines, and Hong Kong. It is expected that this good will tour will create much interest among physicians in the countries to be visited and contribute greatly to American–Asiatic medical rapprochement.

Physicians other than ophthalmologists and their families are also welcome to join this trip.

Those desiring to participate in the postgraduate lectures and seminars on medical subjects pertinent to ophthalmology should contact:

William John Holmes, M.D., Liaison Secretary,
Suite 280, Alexander Young Building,
Honolulu 13, Hawaii.

Inquiries regarding travel arrangements should be sent to:

Compass Travel Bureau,
55 W. 42nd Street,
New York 36, New York.

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Tetracycline and Citric Acid Lederle

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The reason for this decided preference is simple.

For more than four years now, you and your colleagues have had many opportunities to observe and confirm the clinical efficacy of ACHROMYCIN tetracycline and, more recently, ACHROMYCIN V tetracycline and citric acid.

In patient after patient, in diseases caused by many invading organisms, ACHROMYCIN achieves prompt control of the infection—and with few significant side effects.

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Volume 57 JUNE 1958 Number 6

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Medicine's Fourth Estate

Every active physician recognizes the constantly growing importance of his county, state and national medical societies—the three great "estates" of organized medicine in America.

In the past few decades, medical practice has become ever more complex. Doctors today must deal not only with more than a score of fellow medical specialists, but with several score of "paramedical" technicians, many of whom are finding it difficult to adjust themselves to a "table of organization" in which the Doctor of Medicine must, by training and responsibility, be the captain of the team.

Then, too, in the areas of hospital–physician relations, of public health, of medical care prepayment, and of social security, organized medicine is required to think in new terms and to act with decision, if it is to retain the leadership which the people expect of their physicians. The demands of our time call for medical statesmanship of the highest order.

And now, medicine has added a "fourth estate", The World Medical Association, which, though it was founded only a little more than ten years ago, has already earned for itself world-wide recognition as "the international voice of organized medicine."

Our American Medical Association is one of the 53 national medical associations which comprise the membership of The World Medical Association. Within the United States, some 5,500 leading American physicians have formed a supporting committee, known as the United States Committee of The World Medical Association. President of the U. S. Committee is Dr. Austin Smith, Editor of the Journal A.M.A., and its Secretary–Treasurer is Dr. Louis H. Bauer, who has also served as Secretary General of The World Medical Association since its founding in 1947.

Wisconsin may be particularly proud that two of its physicians hold important positions in the World Medical Association. Dr. Gunnar Gundersen, president-elect of the American Medical Association, represents the Association from the United States Committee. He has been active in its program for some years. In addition, Dr. Marvin H. Olson, Wittenberg, is the Wisconsin Chairman for the United States Committee and is Chairman of the U. S. Committee on Individual Memberships for the World Medical Association.

The purposes of the U.S. Committee are those of W.M.A. itself: to work for the highest standards of medical care in all parts of the world; to defend and preserve the freedoms that are essential to good medical practice; to provide a forum for the solution of problems common to physicians the world over; and to promote world peace.

You have an opportunity to play your part in this vital cause by becoming a member of the U.S. Committee of W.M.A. The A.M.A. House of Delegates has urged that every member of A.M.A. join the U.S. Committee. Annual dues are $10.00, and the Committees headquarters are at 10 Columbus Circle, New York 19, New York.

THE MEDICAL FORUM

HOUSE ACTS ON STATE MENTAL HEALTH PROGRAM

Name Head of School Council

OSHKOSH — Frank Stangel, of the Milwaukee public school system, was elected chairman of the Wisconsin State School Health Council at its spring meeting.

Bjarne Romnes, Stoughton, representing the State Department of Public Welfare, was elected vice chairman and Mrs. Elizabeth Moxley, of the Wisconsin Heart Association, Milwaukee, was chosen secretary–treasurer.

The council asked that its subcommittee on preparation of a first aid instruction sheet, for all classrooms in Wisconsin, study methods to finance and distribute it. The sheet includes first aid instructions, suggested school first aid emergency procedure, a sample notification card for illness or emergency, ways to set up an emergency program and suggested items for school first aid kits.

Dr. Hunter and Dr. E. C. Hoyer, Beaver Dam, members of the State Medical Society's Division on School Health, assisted in devising the first aid material.

Members of the council heard reports on health meetings held last fall and announcements of sessions planned for 1958, including the Wisconsin College Health Conference Oct. 10–11 and the Conference on Athletic Injuries Nov. 7, both in Milwaukee.

Medicare Payments Near Half Million

MADISON — MEDICARE payments made in Wisconsin from its inception on Dec. 7, 1956, through April, 1958, totalled $415,248.

This compares with $420,461 paid in Minnesota, and $288,219 in Iowa during the same period.

During April this year, payments aggregated $29,898. In March the total was $28,592.

MEDICARE is the government-sponsored program providing payment of certain medical and hospital care for dependents of military personnel.

Shortage of "Teaching Cases" Cited by Deans

MILWAUKEE—The deans of medical schools at Marquette University and the University of Wisconsin told the House of Delegates that shortage of "teaching cases" was a serious and growing problem of medical education.

Dr. John Z. Bowers, of the Wisconsin school, explained that indigent patients, cared for at little or no cost in hospitals affiliated with medical schools, are studied by medical students during their treatment. The number of such patients, he said, has declined markedly in recent years, causing the problem and much concern.

Dr. John S. Hirschboeck, of Marquette, said higher incomes, among other factors, have cut severely into the number of these patients all over the country, and that medical schools would eventually have to rely on private patients for teaching purposes.

Both deans praised the liaison with S. M. S. and said they were striving toward a goal of treating patients "as a whole," one of the great challenges for medical schools. They said finances remained a major concern, as was recruitment of young people into the health sciences.

Larson Named To New Position

CHICAGO — George Larson, a former assistant secretary of the State Medical Society of Wisconsin, has been appointed convention services manager of the A. M. A.

Assistant director of the A. M. A. Bureau of Exhibits, Larson will coordinate annual and clinical meeting activities, summarize convention requirements, make recommendations for meeting them, and arrange for convention facilities and services.

After 20 years at Madison, Larson left in 1943 to join the A. M. A. staff.

MILWAUKEE—A report of the Division on Nervous and Mental Diseases was adopted in full by the House of Delegates.

The report was primarily concerned with mental health programs and the development of a treatment center for emotionally disturbed children.

The report said:

Mental health has recently blossomed into an object of legislative study and public concern. In an area of many unknowns, fact is piled upon fact, report upon report, prejudice upon prejudice, and opinion upon opinion. There is sufficient evidence of this illness to cause public awareness of a problem. There is enough known about diagnosis and treatment to stimulate confidence that something tangible can be done about the problem.

NO PATTERN

In the broad prospective this can be represented as progress. Yet the current result is an assortment of facts, a hodgepodge of opinions, and a general indecisiveness that has not yet established a pattern.

This observation prompts the division to be reminded of an old maxim: "A little knowledge can be a dangerous thing." Legislative studies, public surveys, and general public opinion should move thoughtfully in this vast area of human behavior. The current study of the Legislative Council in this field is beginning, and we sincerely hope will proceed, in this frame of mind.

MUST BE SOUND

Mental illness, as a condition of human health, should not be isolated from bodily illness. This concept is well-established as fundamental to the preservation of human health and to the diagnosis, care, and treatment of illness in the human being. This being so, your division believes it equally fundamental that efforts to develop facilities, personnel and programs in areas of mental health must find their foundations in sound medical principles and health concept.

(Continued on page 48)

S.M.S. ACCEPTS PORTRAIT OF DR. BEAUMONT BIRTHPLACE

MADISON—"Please accept this picture with the warm regards of the physicians of our state and a part of the ever-strengthening bond of friendship between us."

Thus Dr. Walter I. Russell, New Haven, president of the Connecticut State Medical Society, expressed the action of his society when it presented an oil portrait to the State Medical Society of Wisconsin in May. The portrait is a picture of the birthplace of Dr. William Beaumont in Lebanon, Conn.

When Dr. W. D. Stovall, Madison, president of the Society's Charitable, Educational and Scientific Foundation, introduced the artist to guests attending the annual dinner in Milwaukee, he read Dr. Russell's letter, which follows:

"Mr. President, Ladies and Gentlemen of the State Medical Society of Wisconsin:

"This is to introduce to you Dr. Frederick W. Roberts, surgeon-artist of New Haven. He has painted for your historical collection a picture of the birthplace of William Beaumont in Lebanon, Conn., as a gift from the Connecticut State Medical Society. Please accept it with the warm regards of the physicians of our state and a part of the ever-strengthening bond of friendship between us.

"William Beaumont was born in this simple home of his father on Nov. 21, 1785, and when he left in 1810 to become a school teacher in Champlain, N. Y., he started on what Harvey Cushman has called an 'incredible rendezvous with fame.'

ACTIVE SERVICE

"While teaching at Champlain, he began the study of medicine with Dr. Seth Pomeroy and continued with Dr. Benjamin Chandler at St. Albans, Vt. He entered the U. S. Army as a surgeon's mate in time to be present at the storming of Fort George and the Battle of Plattsburg in 1813.

"His career was in the army and although he found his fame on the middle border of the expanding nation ranging from Mackinac to St. Louis and did not return to Connecticut until 1834 to consult Benjamin Silliman, America's first physiological chemist at Yale and to demonstrate his extraordinary living laboratory, Alexis St. Martin, before the Connecticut State Medical Society of which he became an honorary member in 1833, we look upon him as one of the great medical sons of our small state.

"We share him with you and with the world and are pleased to help 'preserve the memory of the deserving; for perhaps it may prompt others likewise to deserve'."

—(Rolf Lunde Photo)

W.A.T.A. HONORS DR. G. BELLIS

MILWAUKEE—Dr. Glenford Bellis, of Elcho, received the first annual distinguished service award of the Wisconsin Anti-Tuberculosis Association this spring.

Dr. Bellis is believed to be the sole surviving founder of the association. When it was founded in 1908, he was Antigo city health officer. Later he served as assistant medical director of the state sanatorium at Wales and the first superintendent of Muirdale sanatorium in 1915. He retired in 1938, but served as acting director of the Winnebago County sanatorium during World War II.

Speakers at the W. A. T. A. annual meeting stressed trends in research, treatment, problems in case finding, alcoholism and tuberculosis, and home care.

SIX EXHIBITS WIN AWARDS

MILWAUKEE—Winners of awards in physician exhibits at the 117th annual meeting of the State Medical Society were announced at the annual dinner May 7.

Topping the "individual physicians and small hospital" classification was a display entered by Drs. C. R. Dix, Paul Natvig and D. J. Carlson of Milwaukee Hospital. The exhibit concerned the "Treatment of the Traumatic Face."

Second place went to Dr. A. Yale Gerol of the Monroe Clinic, and third to Drs. Gene W. Sengpiel, J. F. Wepfer, J. A. Klieger and Mr. A. Bews of St. Joseph's Hospital, Milwaukee.

CARDIAC DISPLAY

First place in the "individual physicians and large hospitals" grouping was presented to the entry of the University of Wisconsin Medical School, covering cardiac diagnosis and surgery. In charge of the scientific exhibit was Drs. S. L. Burchman and W. P. Young.

Second place was awarded to Drs. Allen Becker and H. B. Benjamin of the Marquette School of Medicine, Milwaukee, and third to Drs. Thomas J. Foley and Jack Selzer of Milwaukee.

MDs Using Planes More and More

MADISON—To more and more physicians, the airplane is becoming almost as important as the little black bag, according to an article in the medical news-magazine, *MD*, February issue.

The article said that the first flying physician is believed to have been Col. David A. Meyers, who died last September in San Francisco at 82. A native of Wisconsin, he learned to fly in World War One, graduating from the Signal Corps first flight surgeon school. Later he became chief surgeon of the Army Air Corps, under the late Gen. Henry H. (Hap) Arnold.

Dr. Meyers published papers on the physiology of flying which became basic literature in aviation medicine. No desk pilot, he collaborated with Lt. Col. William C. Eaker in making the first blind flying experiments and invented the turn-and-bank indicator, still a basic aeronautical instrument.

Using their own small planes, doctors are in easy reach of remote patients, can attend faraway meetings or conventions, and reduce the fatigue and hazards of busy road travel. They are also using planes for vacation travel.

VARIED USES

Dr. Daniel E. Dorchester, Sturgeon Bay, made a house call a few years ago in Louisiana. The patient was a former cherry country resident. More often, he uses his plane for calls on Washington Island and to attend State Medical Society meetings in Wisconsin.

Dr. L. O. Simenstad, Osceola, past-president of the society, has been a member of the State Aeronautics Commission since its inception 13 years ago. He makes much use of his plane.

Dr. Herman A. Heise, Milwaukee allergist, has logged nearly 2,000 hours of airtime since he soloed 11 years ago. Besides calling on patients at distant locations, He flies his own plane to study the atmospheric distribution of pollen, to survey radiation fall-out after atomic bomb tests in Nevada, and to test the effect of new anti-air sickness drugs.

For the A.M.A. meeting in New York City last June, Dr. Heise, who is chairman of the A.M.A. Committee on Alcoholism, flew from Milwaukee in less than five hours to deliver a paper on drunken driving.

A member of the State Aeronautics Commission staff estimated that at least 50 Wisconsin MDs fly their own plane, and another several dozen rent planes when the need arises.

Others known to take to the air include Drs. J. S. Huebner, Fond du Lac; Arthur W. Hankwitz, Milwaukee; R. E. Housner and B. I. Pippin, Richland Center; Robert Krohn, Black River Falls; John A. Beyer, R. H. Jackson Jr., and Frank K. Dean, Madison. And there are many more, of course.

Summing things up, one might say that in this jet age, some Wisconsin physicians are carrying medicine to new heights.

YOUR CREDENTIALS —ARE THEY SAFE?

MADISON—Dr. Marvin H. Olson, chairman of the individual membership committee, U. S. Committee, World Medical Association, reported that the W. M. A. has established a central repository for medical credentials.

During World War II, he said, hundreds of physicians left their country, and their credentials were lost or destroyed. Today many of them are laborers or research assistants because they have no means of proving they are medically trained and fully accredited to practice medicine.

DEFINITE SAFEGUARD

The association is arranging for utilization of a bombproof, fireproof central repository, at which the credentials of physicians can be received through local county medical societies or the A. M. A. Each physician will receive a numbered receipt.

"While we should like to enroll you as a member of the U. S. Committee of the W. M. A., if you are not already one, such enrollment is not necessary for this service," Dr. Olson said. He advised physicians to write the association office at 10 Columbus Circle, New York 19, for additional information.

The 12th general assembly of the W. M. A. will be held in Copenhagen Aug. 20–25. Members are urged to make reservations at once. The 1959 assembly will be held in August in Montreal, Canada.

U. W. Student Winner of SAMA Exhibit Award

CHICAGO—Quinton Callies, of Lomira, a junior attending the University of Wisconsin, was the winner of the medical student exhibit award at the eighth annual meeting of the Student A. M. A. this spring.

His exhibit on farmer's lung was based on a study done with Drs. H. H. Dickie and John Rankin of Madison. The display was scheduled for showing at the A. M. A. meeting in San Francisco in June.

More than 1,000 medical students heard lectures, participated in panel discussions and viewed scientific exhibits at the S. A. M. A. gathering.

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MILWAUKEE WISCONSIN

FOUNDATION OKS PLAN TO AID NEEDY PHYSICIANS

Dr. Stovall Named President for Coming Year

MILWAUKEE—Development of a project to acquire funds for establishment of a home with nursing and dietary facilities for certain deserving physicians was asked by the S. M. S. Charitable, Educational and Scientific Foundation Inc., at its annual trustees' meeting.

The trustees asked the society to undertake an earmarked billing of all physicians in the state to secure funds on a voluntary basis. This money would be used for making grants in aid where it is deemed necessary and helpful, and for the development of a special reserve out of which a home may ultimately be provided.

In its annual report, the foundation stated:

DEVOTION STEADFAST

"The devotion of the physician to alleviation of suffering and service to mankind is sometimes so steadfast that he may not see the opportunity among those of his own colleagues to whom misfortune has come. The number of physicians and their families touched by severe disability, financial insecurity, or similar personal disaster is not great but it is, nonetheless, impressive.

". . . The foundation to date has made only a token contribution to those in most desperate need. The obligation and the opportunity are waiting."

Dr. William D. Stovall, Madison, retiring director of the State Laboratory of Hygiene, was elected foundation president, succeeding Dr. E. L. Bernhart of Milwaukee.

Dr. Arthur J. McCarey, Green Bay, was reelected vice president and Dr. Gordon Schulz, Union Grove, treasurer.

SENN MARKER

Taking note of Dr. J. W. Fon's recommendation that a suitable marker be established at the site of the office–home of Dr. Nicholas Senn in Milwaukee, the trustees approved an appropriation to cover its cost and appropriate ceremonies. Dr. Fons, of Milwaukee, took office as S. M. S. president in May.

Dr. Senn, who served a term as president of the American Medical Association, practiced in Fond du Lac, Ashland and Milwaukee.

LOANS DISCUSSED

Periodic requests from physicians in training as residents who seek loans from the foundation's loan account was discussed. It was decided that first priority on available funds should go to medical students, rather than interns and residents. If sufficient funds are available, then applications from residents will be considered for aid.

The trustees heard a progress report on a study of insurance needs of an aging population. The study is being financed at the University of Wisconsin School of Commerce by Wisconsin Physicians Service.

It was proposed that the study center on the problem of the people in the older age brackets who are today uninsurable in the sense that the term is currently understood. A number of possibilities will be considered in the survey, including limited types of catastrophic insurance.

PHOTO SHOW

The trustees authorized the encouragement and activation of a Wisconsin Physicians' Photographic Exhibition to be presented at the 1959 annual meeting in Milwaukee, under sponsorship of the foundation.

Several classifications of photo entries will be established to show doctors at work, in research and training, in medical history, in public service and administration, and at play.

Dr. R. G. Arveson, Frederic, suggested the possibility of a future travelling exhibit of medical history, to be worked out in cooperation with the State Historical Society.

A recommendation of the House of Delegates that the foundation create by appointment of the president a special committee of five or more members to encourage contributions to the American Medical Education Foundation was approved.

Not One Without The Other

To support socialistic practices in regard to retirement funds requires that, for the sake of consistency, socialized medicine also be supported. If one believes that the federal government should tax everyone to provide an income for each upon retirement or disability, one must also believe that the same government should, with equal propriety, tax everyone to provide medical care for all!

A.M.E.F. Reports M.D. Contributions

CHICAGO—The American Medical Education Foundation reported that 838 Wisconsin physicians made contributions totaling $57,951 in 1957.

The Marquette University School of Medicine, Milwaukee, received $63,501, including $53,687 from alumni sources; the University of Wisconsin Medical School, Madison, $10,555, with $1,708 from its graduates.

Contributions for all 83 medical schools in the country amounted to $4,005,485 from 94,519 donors. This included $3,020,600 from 50,364 alumni.

13 MDs Took Pre-Med Courses at Superior State

SUPERIOR—At least 13 physicians practicing in Wisconsin received all or part of their undergraduate education at Wisconsin State College, Superior.

College officials also reported that another dozen former Superior students were receiving advanced training in medical schools at Wisconsin and Marquette.

Tabulations for the past 35 years showed Drs. Ralph T. Anderson, Milton Finn, John G. Heisel, Fred G. Johnson, M. M. Lavine, Robert R. Mataczynski, Israel Lavine, Edward G. Stack, Jr., and Roger T. Thompson, now practicing in Superior; James F. Maser, Rice Lake; Clarence Samuelson, Hartland; Raymond E. Whitsitt, Madison, and Donald J. Welter, Shell Lake, attended the college at Superior.

"SOCIALIZER" CLAIMS COMPULSORY INSURANCE PLAN GAINS

CHICAGO — "People's minds must be changed so that they will understand that 'freedom of choice' (of physicians) is actually quite meaningless today," Michael M. Davis, a leading exponent of compulsory health insurance, said recently.

He spoke before the Group Health Federation of America.

"The average citizen is in no position to make a wise choice of physicians, particularly not when he may need the services of a number of kinds of specialists," Davis contended.

CHANGES DUE?

"As we view present trends, it seems safe to predict that within ten years no more than ten per cent of payments for medical care will be made on a fee for service basis.

"The term, 'socialized medicine,' is used very loosely, indeed, by many agencies. I would like to point out to them that even the conservative Eisenhower administration has fostered the passage of legislation to provide medical care on a completely socialized basis for 2¼ million dependents of military personnel (Medicare)."

The problem, Davis said, "is one of organization of medical services. Group practice is part of it. Hospital staff organization controlling the quality of care is equally important. Organizations for combating particular diseases or for meeting the needs of particular groups can go on and probably will.

"All of this seems to me to be good, but all such developments must be kept in perspective. Let me repeat that the organization of medical services is the major problem that lies ahead of us.

IRREPRESSIBLE TREND?

"In New York City today, no less than 40 percent of all physicians are working on a salary basis and one-half of these are specialists."

Davis said that medical societies are beginning to realize they "are actually fighting against irrepressible trends . . . Eventually we must extend group payment to the whole population."

PAST PRESIDENTS and guests gathering for their annual luncheon at the State Medical Society meeting in Milwaukee May 6–8. In attendance were (left to right, seated): Drs. William D. Stovall, Madison; R. G. Arveson, Frederic; H. E. Kasten, Beloit; Jerome W. Fons, Milwaukee, the incoming president; L. O. Simenstad, Osceola; G. W. Slagle, Battle Creek, president of the Michigan State Medical Society; H. Kent Tenney, Madison, and L. S. Reavley, Sterling, president of the Illinois State Medical Society. Standing, same order: Dr. A. H. Heidner, West Bend; Mr. Charles H. Crownhart, society secretary; and Drs. M. A. McGarty, La Crosse and Joseph C. Griffith, Milwaukee.

—(Genack Studio, Milwaukee)

Foes of Fluoridation Assailed in Pamphlet

NEW YORK—Suspicious people whose counterparts once opposed vaccination and pasteurization now are depriving millions of children of the advantages of fluoridation, Dr. Louis I. Dublin, consultant to the Institute of Life Insurance, said.

His statement is included in a 25-page pamphlet, "Water Fluoridation: Facts, not Myths," published by the Public Affairs Committee.

"Once citizens make it their business to learn the facts, opposition to water fluoridation will disappear like a bad dream," Dr. Dublin said.

Next to the common cold, tooth decay is probably the most universal disease suffered by mankind, and tremendous savings can be made through fluoridation.

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New Threat to Free Choice of Physicians in Medicare Program

WASHINGTON, D. C.—Free choice of physicians is being threatened in the government's Medicare program, according to the Gross Washington Report.

The House Appropriations Committee has again shown itself critical of the Defense Department's policy of allowing dependents to elect civilian care even though military facilities are nearby and available.

In late May, the committee voted a substantial reduction in funds for the civilian phase of the program, from a requested $71,900,000 to $60,000,000. Unless reversed in the house or the senate, the action means a limitation on the free choice of physicians and hospitals that has prevailed since Medicare was started in December, 1956.

To stay within the lowered budget ceiling, military officials will be forced to order civilians in the areas of most military hospitals to cease obtaining their medical care from civilian physicians and hospitals, and to go to military hospitals and consult military physicians.

In the area of military medical facilities, the effect probably will be to wipe out civilian Medicare. Nationwide, one of every six dependents now receiving civilian care would be ordered to go to a military facility instead, inasmuch as civilian funds may be sliced at least 17 per cent.

Recently Maj. Gen. Olin F. McIlnay, deputy surgeon general of the U. S. Air Force, was grilled at length by Reps. Sheppard (D–Calif.) and Flood (D–Pa.), members of the subcommittee.

Maj. Gen. McIlnay testified:

"I, personally, was one of those who created even some animosity by fighting strongly to limit the privilege of the dependent, and to insure that he should get his medical care from a medical facility of the services when it was available."

He cited figures showing that the same medical and hospital care for dependents costing the government an average of $46.58 a day is being given in military facilities for $26. The latter figure includes salaries of physicians and other attendants.

This contention cannot be defended, Dr. F. J. L. Blasingame, general manager of the A.M.A., said in a letter to the subcommittee. He held that military cost figures omit many actual expenses, such as depreciation, fringe benefits, recruitment and training, and the like, all expenses which must of necessity be included in civilian costs.

Dr. W. J. Kennard, acting director of the A.M.A. Washington office, pointed out that the civilian Medicare is not costing more than Congress anticipated.

(The State Medical Society of Wisconsin, through its Commission on Medical Care Plans, is directing the Medicare program in Wisconsin. The society has always advocated and fought for free choice of physicians to maintain the most desirable physician-patient relationships).

The U. S. Air Force stands first among the armed forces in estimated expenditures for Medicare in the next fiscal year. It is asking $28,220,000 to pay civilian physicians and hospitals for services to dependents of airmen. The Navy is asking $23,494,000, the Army $18,532,000.

M.V.D. Reports 1957 Accidents

MADISON—Of 57,460 vehicular accidents in Wisconsin last year, 185 involved drivers with physical defects, the State Motor Vehicle Department reported. Six fatalities resulted from these accidents.

The department said it had no breakdown of the physical defects, listing them under one classification only.

The department said 1,444 drivers involved in accidents were asleep at the time of impact, and 2,870 others had been drinking.

There were 765 persons killed on Wisconsin highways in 1957. More than 17,300 others were injured. Collisions with other vehicles accounted for 38,777 accidents resulting in 263 fatalities and 10,559 injuries. Most frequent violation was failure to yield right-of-way.

ANNUAL MEETING 1958

More than 1,750 Wisconsin physicians attended the 117th annual meeting of the State Medical Society in Milwaukee May 6–8. On the adjoining page are some pictures taken at the sessions:

1—Drs. E. L. Bernhart, Milwaukee, immediate past president of the Charitable, Educational and Scientific Foundation Inc., and E. M. Dessloch, (right) Prairie du Chien, vice chairman of the Section on Medical History, stopped to chat before the Foundation meeting.

2—The Arena, next door to the Milwaukee Auditorium where the scientific meetings were held and where the exhibits were on display, carried a sign, welcoming S. M. S. members to the meeting.

3—Dr. W. D. Stovall, Madison, chairman of the society's Section on Medical History, accepted an oil portrait showing the birthplace of Dr. William Beaumont in Lebanon, Conn., in 1785. The donor was artist-surgeon Dr. Frederick W. Roberts (right) of New Haven, Conn., who made the presentation on behalf of the Connecticut State Medical Society.

4—Physicians took turns registering for the general sessions, specialty meetings and round-table gatherings.

5—Dr. H. E. Kasten (left), of Beloit, outgoing president of the society, and Dr. W. B. Hildebrand, Menasha, president-elect, presented a special citation to Dr. Elizabeth Comstock, Arcadia, for her 57 years of medical practice and her interest in medical history.

6—General scene in the House of Delegates.

7—Dr. R. S. Hirsch, Viroqua, vice speaker, is shown at the microphone during the meeting.

8—Doctors, a record number of them, attended the round-table meetings. In this picture they are shown lined up for luncheon.

9—Dr. W. B. Hildebrand, Menasha, president-elect, congratulates Dr. Thaddeus D. Smith, Neenah, one of the 20 Wisconsin physicians initiated into the society's exclusive "50 Year Club."

10—Round-table scene.

11—Dr. Elizabeth Comstock, Arcadia, studies one of the scientific exhibits at the auditorium.

12—An unidentified physician is shown at the golf tournament, ready to tee off.

13—Dr. Hildebrand is addressing the delegates, with Dr. H. E. Kasten, Beloit, and Dr. J. W. Fons, Milwaukee, outgoing and incoming president respectively, at the left.

ANNUAL MEETING—1958

MENTAL HEALTH . . .

(Continued from page 41)

A focal point in the current concern about mental health is a proposal for the establishment of a treatment center for emotionally disturbed children in Wisconsin. On this problem your division wishes to make a few generalizations which must pervade all discussion on this topic.

There are many facets to the problem of the emotionally disturbed child. The incidence of emotional disturbance in children touches every ethnic, religious, social, cultural and economic background. There is a multitude of different attitudes and opinions as to causation. Medical attitudes must be measured and joined with those of sociologists, psychologists, educators, the judiciary, and the clergy. From a scientific standpoint, it should be understood that basic research in a field of emotional disturbance is but newborn and, therefore, facilities should begin small and grow with experience. Further, the very nature of the condition often causes the adult to become as emotionally disturbed about the problem as the child is about himself and his relations with others.

NEW PERSPECTIVE

The situation in the care of the emotionally disturbed child today might be likened to the status of tuberculosis treatment 50 years ago. Combined research, training and treatment have overcome fear and ignorance and brought tuberculosis to an entirely controllable stage. Tradition has established a mental disease as something to be handled by commitment, a carry-over from the days when the jail-house was thought to be the proper place for the insane.

But mental illness is a state of health, not a violation of law. Its prevention and treatment must be regarded in the highest health sense if those who are or might be afflicted can be expected to willingly and voluntarily accept preventive and therapeutic measures.

With regard to the proposed treatment center for emotionally disturbed children, the division and its Subcommittee on the Disturbed Child have been most active in meeting with the Legislative Council Committee on Mental Health, the Wisconsin Association for Mental Health, and representatives of the University of Wisconsin–Marquette University medical schools, State Department of Public Welfare, State Board of Health, and the State Department of Public Instruction.

In general, the division has concluded as follows:

1. There is a genuine need for the development of a special state treatment facility, well-integrated with other mental health facilities, for the severely emotionally disturbed child.

2. In the beginning, such a facility should be relatively small (perhaps 25–30 beds) and so designed as to allow expansion as experience and staffing permits.

3. The unit should preferably be University of Wisconsin centered and medically oriented so that teaching and research opportunities can be utilized to the fullest while at the same time meeting service needs of the state to the best of its ability. In any event, the treatment center must be closely allied to the medical school for teaching and research purposes.

4. The center should have its emphasis on health care rather than corrections. It requires medical direction and its health concept requires a broadened policy of admissions.

The division is continuing its meetings with representatives of the University of Wisconsin Medical School and the several state departments involved. It anticipates that the Legislative Council Mental Health Committee will provide an opportunity for the division to express its opinions at some appropriate point in its deliberations. It is possible that the division may have a supplementary report to present to the House of Delegates.

In any event the division points out the necessity for regarding the proposed treatment center as one part of the total efforts of the private medical profession, child guidance centers, local hospitals and county institutions, group homes, foster homes, the diagnostic center, the state's two university medical schools, and a number of state departments. The closest kind of coordination and cooperation between these elements of facilities and personnel is essential for the proper handling of the mental health problem, not only for the disturbed child but for all the citizens of the state.

Although the question of mental health and the emotionally disturbed child has occupied a large portion of the division's time and effort during the past year, a number of other interests have been pursued.

SEEK COUNTY HELP

The division recommends that all county medical societies and voluntary health agencies in Wisconsin come fully acquainted with and attempt to implement to the fullest the American Medical Association guiding principles for relationships with voluntary health agencies.

A Subcommittee on Tranquilizers has been established to study this subject in Wisconsin and develop a report for submission to The Wisconsin Medical Journal and possible presentation to the teaching programs of the state.

The Subcommittee on Psychiatric Training has been reactivated in the hope that it can provide added impetus to plans for expansion and improvement of the psychiatric training program at the University of Wisconsin Medical School.

Likewise the Committee on Commitment Laws has been reactivated for the purpose of exploring the problem of "insanity before the court."

OFFER NEW PUBLIC RELATIONS FILM

MADISON—"Even for One," a dramatic film showing the importance of trusting in a physician's judgment, is available from the S. M. S. Offices, Box 1109, Madison 1, for public showings.

A 16 mm film, "Even for One" runs 28½ minutes and has been described as excellent for service groups.

A.M.E.F. REPORTS CONTRIBUTIONS

CHICAGO—The American Medical Education Foundation reported it had received contributions from the following Wisconsin physicians this spring:

Drs. John A. Cox, A. B. Fidler, William L. Herner, C. H. Hickey, Charles L. Junkerman, J. F. Kuzma, Robert P. Montgomery, Samuel W. Rosenberg, Donald M. Ruch, C. R. Schneider, Chester Wade and Victor J. Wong, of Milwaukee; Benjamin H. Glover, Madison and Michael J. Kuhn, Wauwatosa.

Facts about

"THE DOCTORS' PLAN"

THE BLUE SHIELD PLAN
OF THE
STATE MEDICAL SOCIETY OF WISCONSIN

WISCONSIN PHYSICIANS SERVICE

PREPARED BY THE COMMISSION ON MEDICAL CARE PLANS

How Trustees Can Best Serve "The Future of Blue Shield"*

By LOUIS H. BAUER, M. D., D. Sc. (Hon.), F. A. C. P.**

In surveying the various Blue Shield Plans, we find that the Boards of Trustees vary widely in their makeup, their relationship to the medical profession and in their attitudes toward basic Blue Shield philosophy. Boards also vary in their administrative functions and methods.

I believe that all this variety tends to weaken Blue Shield and that certain very basic principles should govern *all* Boards of Trustees. Boards' adherence to these principles may decide the future of our plans.

In an article of mine, recently published, entitled, "The Future of Blue Shield", I gave examples of the effects that follow upon a lack of unity in the medical profession. I am sure many of you are personally aware of how government controlled medicine was swept into countries like England, Sweden, Greece and Japan. I'm also sure that you are following the events in Belgium, France, India and Thailand.

You know that wherever the profession has stood together as a unit, it has been able to make a successful stand against complete government encroachment.

Today, in the United States, since most patients use insurance as a means of paying for their medical care, the profession has an excellent opportunity to make a firm, united stand against our government's further intervention in medical care. All that the doctors need do is to join behind one, single plan that they themselves sponsor and control. (Whether or not the physician approves of insurance is beside the point.) Insurance is here to stay, whether or not we like it. There is absolutely no turning back to the system in vogue that we knew 25 or more years ago.

To begin with, the board itself must be under the direct control of the medical societies, either by virtue of a majority representation of physicians on the board or by whatever other effective means of control the societies devise.

It may well be that the societies feel better represented by certain knowledgeable, competent laymen. If so, all well and good. The point is: the medical societies should have the ultimate power. We cannot expect the societies or their physician members to continue supporting the plans unless this power is given them. The reasons for this are self-evident: we are offering our members physician services. We ask physicians to agree to specific fee schedules and, in the Service Benefits plans, we ask the physician to accept our payment as full reimbursement when he treats patients in certain income brackets. The doctor cannot be expected to agree to these provisions unless he has a controlling voice in establishing them.

As to nonmedical members of the board, it should be remembered that physicians taken as a whole are poor businessmen and poor financiers. They need the advice of those who are experienced in these fields. Therefore, there is a need on Blue Shield Boards for business executives, financiers, public relations directors and actuaries.

(Continued on next page)

* Copy of address to Conference of Blue Shield Plans, Chicago, at its program session on April 29, 1958.

** Chairman, Board of Directors United Medical Service, Inc.

How far the additional general public or labor should be represented is a controversial question. This is something each plan must decide for itself, keeping the following in mind: other plans, such as commercial plans, also sell medical care insurance. Labor unions, too, set up health plans—but the medical profession plays no part, nor does it pressure to play a part on the governing boards of these organizations. However, just as these organizations should *consult* medicine, so should medicine consult the general public and labor. Board membership on the other hand, is a moot point.

I have discussed the composition of the Board, and I should next like to speak of the specific things a board may do to improve its relations with the medical societies.

Thus far, only Blue Shield has offered the doctors the control they desire and need. In some Blue Shield plans, however, this control has weakened, or has been taken away from the doctor altogether.

It is not uncommon to hear remarks such as the following from doctors:

> "Our Society has nothing to say about our local Blue Shield Plan."
> "We are never consulted about policies."
> "Dr. A. was originally suggested by us for the Board, but he never tells us anything, and he no longer represents us."

Then, on the other side of the picture, we have remarks from the Plan Directors such as:

> "What right did the medical society have to do that?"
> "What do we want doctors for when we are discussing coverage?"

All this points out the fact that some of our plans are no longer Doctors' Plans except in name. Not all of this is Blue Shield's fault, but often it is the fault of the medical society in letting control of the plan slip out of its hands. The fact remains, however, that whatever the reason, *it is the duty of the Board of Trustees to see to it that this control is strengthened or, where necessary, returned to where it belongs—in the hands of the profession.* The key to the correct balance of Blue Shield strength lies in the relationship of the board to the medical societies it represents.

Most important—Blue Shield must never become a third party! It must only continue as an agent of the medical societies, doing for them what they cannot do for themselves —administrative work, devising contracts, and so on. It is up to the medical members of the board to see to it that their medical societies are constantly informed of these activities; and these same medical members must bring the voice of the societies to board meetings.

The medical societies should have the right to nominate the medical members of the Blue Shield Board. Ideally, in small plans, they can perhaps elect them. But no physician trustee should be elected unless he has been at least nominated or approved by the medical society of which he is a member.

Plan trustees must see to it that no major change in policy is approved by the board unless the changes first meet with the approval of the medical societies. This applies to such plan policies as the extent of coverage offered, service benefit levels, fee schedules and so forth.

Of course, some recommendations of the medical societies may not be feasible, because of financial or actuarial considerations. It is my opinion, however, that no item in the schedule of allowances should be set merely on the basis of funds available. If a reasonable fee, one acceptable to the physicians, is not possible, then either that allowance should be *made* possible, financially, or the item should be paid for on an indemnity basis. No physician should be asked to accept as full payment an allowance which he and his colleagues consider inadequate for the services rendered.

Trustees cannot be aware of the thinking of the members of their societies unless they

attend their meetings, report what the plan is doing, and ask for suggestions. The medical society should feel that the trustee elected to represent it is conversant with the thinking of that society—that he is, in fact, their representative.

Trustees, too, should encourage their societies to appoint committees to study and consider all matters pertaining to Blue Shield.

Besides having a responsibility to the medical societies, the board also has a major responsibility toward its subscribers. These responsibilities manifest themselves in legal matters, in matters dealing with finances, and with information to subscribers. Briefly, I would like to touch on each one.

The legal obligation is, of course, most important. The corporation is licensed under law. Trustees must, therefore, see to it that all acts of the corporation are in full compliance with the law. The types of coverage, the wording of contracts, control of payments, the nature of advertising, of investments, expenditures of funds, etc., all may have legal aspects and must, therefore, be carefully considered.

The Board of Trustees should employ competent legal counsel and should be guided by his legal advice as a matter of protection to the subscribers, the corporation and the trustees. The legal counsel should attend all meetings of the trustees and executive committee. He should have every matter having any possible legal implication referred to him for advice.

With regard to finances—there will doubtless be members of the board who are financial experts. However, the board should appoint a finance committee to make recommendations as to investments. Ideally, this committee should recommend hiring an investment company to handle the details of investing. But the policies governing these investments should properly be decided by the board on the recommendations of the Finance Committee.

As for educating the public, it may seem to some that this is an obligation not within the compass of a board's duties. I do not agree. For the public is, truly, the plan's most intimate concern. The public buys the contracts and their needs and desires must be determined. The public must be kept informed of the activities of the plan; of the contents of their contracts; and, while this may seem obvious, the public also must be educated to distinguish between Blue Cross and Blue Shield. I am sorry to have to admit that even the medical profession needs education on that.

All this brings into play the matter of advertising and literature used for distribution to both doctors and subscribers. Trustees should be familiar with all publications, so as to be able to formulate the general principles governing the makeup of their contents. This would include the contents of any newsletters, bulletins, radio and television programs, as well as talks before medical societies or other groups. Trustees naturally are not expected to prepare this material nor to send it out, but arranging for proper distribution and dissemination is the board's duty. Board members may also arrange speaking engagements for themselves or for their plan executives.

Furthermore, the trustees should attend as many national meetings as possible so as to be abreast of the thinking in other parts of the country. UMS has found it very beneficial to invite not only its medical trustees but officials of its sponsoring medical societies to attend the Annual Professional Relations Conference. This conference has given them an insight into the philosophy and problems of Blue Shield that they could not otherwise have obtained.

Having touched on the board's relationship to the profession and to the public there remains but one major area of mutual interest that is the concern of every trustee: that is the board's relationship to Blue Cross.

Originally Blue Shield was very small; and it started out five years after Blue Cross. Blue Shield, therefore, had very much to gain by a close relationship to Blue Cross.

Because it was larger and had a greater fund of experience, Blue Cross was able to help the younger plan immeasurably. Both plans worked closely, both benefited from the sharing of talent and experience and both grew quickly. There was a tendency in those early years, because Blue Cross was the older, more experienced partner, for Blue Cross to become the dominant half of the liaison. Now, however, the situation is changed. Blue Shield has a depth of experience it lacked before and is growing faster than Blue Cross. I believe that the two plans should now be partners on an equal footing. Neither should dominate the other.

If we look at the plans around the country we see some of them completely divorced from one another. Others are almost completely unified, even to having the same personnel on both boards. Still other plans are separate except for a joint Enrollment Department. This especially in the larger plans, has often proved a great convenience and saving to both plan and subscribers.

Complete integration, even of just the boards, however, does not seem to me to be in the interest of anyone. Blue Cross is controlled by the hospitals, and Blue Shield by the physicians—and their philosophies differ in so many respects that it is hard to imagine any joint board working smoothly without one plan overpowering the other.

It is very disheartening to view the state of affairs that exists in those areas where the two organizations are moreorless one in fact, even if not in theory. Because Blue Shield has been the junior partner it seems often to act hesitantly, without vigorous conviction in the course it must follow, content to be hand-led and spoon-fed by the elder Blue Cross. What is to be gained by one plan hiding in the shadow of the other? Blue Shield is no longer in swaddling clothes. It has reached adult state. Both plans are working to serve the community. They should work in harmony, yes,—share those duties that will benefit both plans—but each plan should be master of its own fate.

The first step that should be taken to establish a Blue Shield plan's independence is the appointing of a director separate from Blue Cross. Certainly, when Blue Shield was in its infancy, it could not afford a full time director. Since there was a need to establish a good deal of early planning, much was gained by having Blue Cross' director also serve Blue Shield. But, again, today things have changed—and just as there is much to be gained by having separate boards, so is there much to be gained by each plan having its own director. The duties and responsibilities of each plan have grown to too great a height to allow one man to fulfill both jobs effectively without one being secondary to the other.

These are matters which must be decided by the Boards of Trustees of the Plans, but they cannot be decided intelligently unless each trustee is thoroughly familiar with all aspects of his plan's activities. It has been found, for instance, that some boards meet only once or twice a year, and that the operation of the plan is left entirely to the Plan Director or to the Board's Executive Committee. This is unfortunate. Unless the board meets frequently, how can the trustees keep abreast of what is going on, or how can they expect to decide the proper course of action for the plan in matters that come up from day to day? Executive committees are excellent organizations but they should meet to handle emergencies, to sift material and make preliminary studies for presentation to the Board itself. In my opinion, the executive committee should not habitually be given the full authority of the board.

By the same token, the Plan Director should be expected to carry out the board's policies—but the director himself should not be the one to determine policies. Plan policy should be determined by the board and must reflect the expressed desires of the medical societies. The Plan Director must carry out these desires.

Such matters as co-insurance, experience rating, and service benefits are proper mat-

ters for Trustees to discuss. Their decisions, however, must reflect the many responsibilities they have to the public and the medical profession. Trustees must decide whether Blue Shield is to be a community plan or a plan for a favored few. But we must keep uppermost in our thoughts, that if Blue Shield does not protect the *entire* community —including the poor risks—the government will step in. When it does, it will not just take the poor risks, but will sweep up everyone without exception. All one has to do is to look abroad to see what will happen if voluntary health insurance fails in this country. I will go even further and say that if Blue Shield should fail—then we shall most assuredly see government medicine moving in to take over.

In conclusion, I think I can safely say that being a Trustee does not involve just a name or a title, but entails a mature and substantial responsibility for policies and education. Blue Shield must not fail, but it will unless the Plans work in close cooperation with their medical societies, and convince them that the plan is not a third party but only their agent, carrying out certain technical, administrative aspects of the program, the doctors, themselves, have set up.

Now, may I make an appeal to the profession itself? Medicine can no longer be practiced as it was 25 years ago. It involves not only art and science but socioeconomics as well. Physicians as individuals and medical societies as a whole must take an interest in the whole problem of rendering adequate medical care. The medical profession has had a 2500 year tradition of ministering to the sick. It must keep up that tradition and must, itself, take the leadership in programs to ensure proper medical care. Unless it does, the leadership will be taken away by others.

During the past 11 years, I have made two trips around the world and 21 trips to Europe (and I'm going again tomorrow). I have seen what has happened when the medical profession weakened and permitted itself to be thrown off the tracks by a government machine. I have seen the debasing of the standards of medical care. I shudder to think what will happen—in fact, what is happening right now—in this country as a result of the apathy of the medical profession.

As Trustees, see to it that your sponsoring bodies are alerted to these problems. And elect to your boards far-seeing, capable and energetic people.

FUTURE MEETING PLANS OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

1959—April 5–9, Atlantic City, N.J. Headquarters: Traymore.
All activities except breakfast conferences and banquet in convention hall.

1960—April 24–27, Chicago, Ill.
Headquarters: Morrison Hotel.
All activities in hotel.

1961—April 16–21, Boston, Mass.
(If no convention hall is available, this meeting will have to be transferred to The Americana, Bal Harbour, Miami Beach, Fla.

URETHRAL CATHETERS FILM

A new film, *Urethral Catheters*, has just been made available by the Smart Family Foundation as a public service to physicians, medical organizations, nursing schools, and medical schools. The film is designed for professional and pre-professional showings to teach the history, use and applications of the modern urethral catheter. The wide variety of urethral catheters and their purpose are emphasized and each is shown in turn.

A 16mm sound motion picture, 30 minutes running time, *Urethral Catheters*, may be purchased for $50 in color or $10 in black-and-white from the Smart Family Foundation, 65 E. So. Water St., Chicago 1. Illinois. The film may be rented from either the American Medical Association or the American Hospital Association.

Society Proceedings*

Ashland–Bayfield–Iron

The Ashland–Bayfield–Iron County Medical Society with 29 members, ladies and guests met for a dinner meeting at the Platter at Ashland on April 22. Mr. Charles Crownhart informed the group of legislative problems and gave recommendations on how to cope with them. He also discussed the Blue Cross and Blue Shield plans.

During the business meeting a motion was passed to extend an invitation to *Dr. C. M. Ihle*, Eau Claire, to conduct a crippled children's clinic.

Eau Claire–Dunn–Pepin

"Diagnostic and Therapeutic Advances in Liver Disease" was the title of the Grand Rounds film shown to the members of the Eau Claire–Dunn–Pepin County Medical Society at its April 28 meeting. The site of the meeting was the Hotel Eau Claire.

* Physicians whose names are printed in italics are members of the Society.

Fond du Lac

The Fond du Lac County Medical Society met April 24 at the Elks Club in Fond du Lac. Three members of the Marshfield Clinic, *Drs. F. John Gouze, George G. Griese* and *Ben R. Lawton* addressed the members. The subjects of their talks were: "Cholesterol and Coronary Artery Disease in Relationship to Fat in the Diet", "Care of the Baby of a Diabetic Mother", and "Treatment of Acute Traumatic Chest Injuries", respectively.

Green Lake–Waushara

Members of the Green Lake–Waushara County Medical Society and their wives met April 24 for a dinner meeting at Van Rhyn's at Green Lake. Following the dinner the Auxiliary and the County Medical Society held separate business meetings. Guest speaker for the doctor's program was *Dr. F. G. McMahon* of the staff of Wisconsin State General Hospital at Madison. Doctor McMahon spoke on diabetes. A new schedule for welfare work was discussed at the business session.

Outagamie

The Outagamie County Medical Society met on May 15 to hear Governor Vernon W. Thomson. The meeting was held at the Appleton Elks Club.

Polk

Dr. Donnell Etzweiler of St. Louis Park, Minnesota, spoke at the April 17 meeting of the Polk County Medical Society held at Paradise Lodge in Balsam Lake. "Medical and Surgical Emergencies in the Newborn" was the subject chosen for his address. During the business meeting discussion was held concerning the State Medical Society annual meeting and the resolutions to be presented at the convention. In support of Medical Education Week the doctors were to take part in representing the medical profession at the high school vocational guidance clinics.

Sauk

On April 8 the Sauk County Medical Society held its monthly meeting at the Warren Hotel in Baraboo. *Dr. Henry Okagaki*, Assistant Professor of Orthopedics Surgery at the University of Wisconsin Medical School, presented a paper on "Common Orthopedic Problems in Children". *Dr. M. F. Huth*, president, announced that the chairman of the Public Policy, Public Relations Committee is to be *Dr. K. D. Hannan*. The committee members are: *Drs. J. A. Tibbitts, Gibbs W. Zauft*, and *I. A. Galarnyk*.

Principal business at the May 13 dinner meeting at the Warren Hotel was a report given by *Dr. C. R. Pearson* on the sessions of the House of Delegates.

Trempealeau–Jackson–Buffalo

The Trempealeau–Jackson–Buffalo County Medical Society met April 29 at Club Midway. A discussion on social security was the main topic of business for the evening.

Vernon

Mr. Charles Crownhart and Mr. Robert Murphy, attorney for the State Society, addressed the Vernon County Medical Society at the April 16 meeting held at St. Joseph's Hospital in Hillsboro. Mr. Murphy discussed the subject of social security as related to physicians and Mr. Crownhart spoke on recent legislation as related to the medical profession. The talks were followed by a question and answer period.

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During the business session the members voted against compulsory social security for the medical profession.

Walworth

The Walworth County Medical Society's members heard *Dr. Ralph Campbell* of Madison lecture on "Uterine Prolapse". Their meeting was held April 10 at the Colonial Hotel in Delavan.

Washington—Ozaukee

The Linden Inn at Slinger was the meeting place of the Washington-Ozaukee County Medical Society on April 24. The members discussed the county's need for a convalescent home and appointed a committee consisting of Drs. *M. E. Monroe, A. Heidner,* and *A. Grundahl* to investigate the matter further. The Society also voted on the subject of having physicians under the social security system, the result being that the members expressed opposition to the measure.

Waukesha

Twenty-seven members of the Waukesha County Medical Society met February 12 at Oakton Manor in Pewaukee. Following a talk on treatment of acute renal insufficiency given by *Dr. Earl Schulz* of Waukesha, a business meeting was held. Among subjects discussed were the operation of the new Geriatrics Committee, the Jenkins Keogh bill and the Forand bill, with the members endorsing the Jenkins bill and opposing the Forand bill.

Wood

Dr. D. P. Smiley, Marshfield, spoke to 24 members of the Wood County Medical Society at its April 24 meeting held at Wilbren's in Wisconsin Rapids. The paper presented was entitled, "Congenital Dysplasia of the Hip". Also on the program was a discussion by *Drs. R. W. Mason* and *G. S. Custer* on the agenda for the delegates' meeting.

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Milwaukee Neuro-Psychiatric Society

A scientific session featuring Dr. Benjamin Boshes, chairman of the department of neurology and psychiatry at Northwestern University Medical School, was presented by the Milwaukee Neuro-Psychiatric Society on May 21 at the University Club of Milwaukee. A business meeting with the election of officers and a dinner were also scheduled for the program.

Wisconsin Psychiatric Association

The Wisconsin Psychiatric Association met in April at the Top Hat Restaurant in Middleton. A panel of three lawyers, William Platz of the attorney general's office, Frank Remington of the University of Wisconsin, and Gordon Sinykin, Madison attorney, discussed legal testimony by psychiatrists. During the meeting *Dr. Max Smith* assumed the post of president; Dr. Leonard Ganser was named president-elect; *Dr. Gilbert Tybring* was chosen secretary, and *Dr. Harold Lubing* was elected treasurer. All four doctors are from Madison. *Drs. Benjamin A Ruskin,* Milwaukee, and *Albert Lorenz,* Eau Claire, were named to the council with Dr. Robert Roessler, retiring president, becoming an ex officio member of the council.

Wisconsin Section of the American Academy of Pediatrics

Officers elected by the Wisconsin Section of the American Academy of Pediatrics at its May 8 Milwaukee meeting are: *James Conway,* M.D., Milwaukee, chairman; *James Vedder,* M.D., Marshfield, vice president; *Harry Waisman,* M.D., Madison, secretary; *John J. Suits,* M.D., Marshfield, alternate delegate; and *Kenneth Winters,* M.D., Milwaukee, delegate.

Wisconsin State Urological Society

The annual meeting of the Wisconsin State Urological Society was held recently at Manitowoc, during which time the following officers were elected: *Drs. Frank Hilpert,* Racine, president; *Benjamin Brunkow,* Monroe, vice president; and *Donald W. Calvy,* Milwaukee, secretary-treasurer.

The Society voted to assist the State Medical Society of Wisconsin in putting on a half-day program of Urological Topics at the latter's annual meeting in 1960.

Section on Internal Medicine

At the meeting of the Section on Internal Medicine of the State Medical Society of Wisconsin held May 7 in Milwaukee, the following men were reelected as delegate and alternate delegate for the coming year: *Louis J. Kurten,* M.D., Racine, delegate, and *Robert L. Gilbert, M.D.,* La Crosse, alternate delegate.

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OBITUARIES

Dr. Charles A. Dockery, a practicing physician in South Milwaukee for 52 years, died February 10 at the age of 88.

Doctor Dockery was born in Cedarburg in 1870 and graduated from Milwaukee Medical College in 1903. Before locating in Milwaukee he practiced for a year at Fox Lake. He was one of the few survivors of the Wheelman's Association, a bicycle racing club. Doctor Dockery was a member of the fire and police commission and served as health commissioner for the city of South Milwaukee. He was a staff member at St. Mary's Hospital, Racine, and St. Anthony's Hospital, Milwaukee.

Survivors include his wife, Margaret; two daughters, Mrs. Margaret Mary Poblocki and Mrs. Kathleen Hart, both of Milwaukee; and four sons, Attorney Maurice, Robert, and Thomas of South Milwaukee, and Doctor Joseph of Racine.

Dr. E. S. Sullivan, 63, of Madison, passed away April 8 after a lingering illness.

Born in 1894 at Eau Claire, Doctor Sullivan attended the University of Wisconsin Medical School and received his medical degree from Columbia University College of Physicians and Surgeons in 1918. He joined his brother, Dr. Arthur G. Sullivan, in medical practice at Madison in 1919 where he practiced until his death. During this time, Doctor Sullivan was on the staff of St. Mary's and Madison General Hospitals, Madison, St. Joseph's Hospital, Dodgeville, and St. Mary–Ringling, Baraboo.

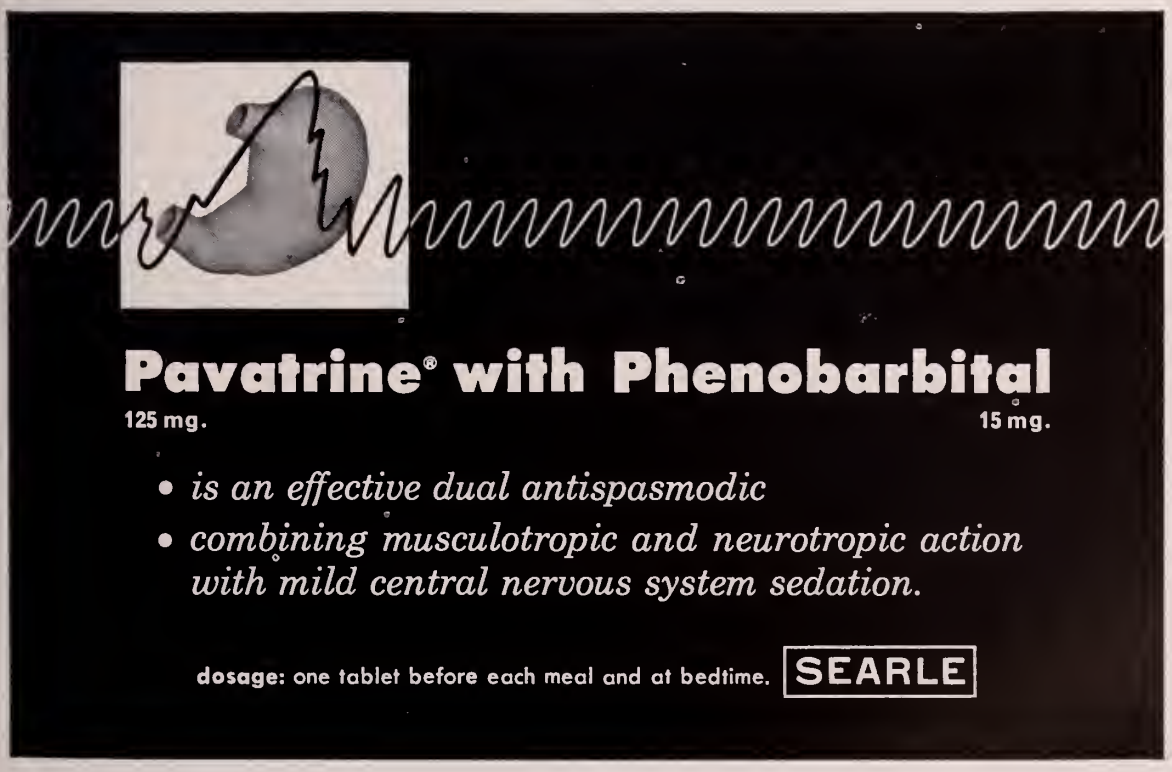
He was formerly a member of the Dane County Medical Society, the State Medical Society of Wisconsin and the American Medical Association.

Surviving are his wife; a son, Doctor Eugene, Jr., Portland, Oregon; and a daughter, Mrs. John R. Meyer, St. Paul, Minnesota.

Dr. E. N. Brown, 82, died April 12 in Madison. He had been a practicing physician in Arena since 1905.

Doctor Brown was born in Ohio in 1875. He began practice in Arena after completing his medical education at Northwestern University and an internship in Chicago, Illinois. In appreciation for his many years of service to the community, the citizens of Arena gave a program in his honor in 1953. Besides his private practice, he was a consulting physician

for "the butterfly stomach"



at the Jackson Clinic, Madison. Doctor Brown entered retirement in 1957.

His wife, Gertrude, survives.

Dr. G. C. Ruhland, formerly of Milwaukee, died April 14 in Washington, D.C. He was 79 years of age.

He was a native of Milwaukee, having been born there in 1878. After graduation from Wisconsin College of Physicians and Surgeons in 1904, Doctor Ruhland served as head of the health department laboratories in Milwaukee for eight years and then became health commissioner. He served in this capacity for 12 years, leaving in 1924 to assume a similar position for the city of Syracuse, New York. In 1935 he moved to the District of Columbia and acted as health officer until 1949. Doctor Ruhland retired in 1951 after serving for two years as executive director of the District of Columbia division of the American Cancer Society.

For a number of years, Doctor Ruhland was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin and the American Medical Association.

Dr. C. S. Carmichael, Fort Atkinson, succumbed May 1 after a lingering illness. He was 78 years of age.

He was born at Montreal, Canada, in 1879 and was a 1907 graduate of Marquette University School of Medicine. Doctor Carmichael was formerly a senior physician at Mendota State Hospital, Madison. He was located at Vesper and at Wisconsin Rapids before moving to Fort Atkinson in 1945.

Previous membership affiliations included those with the Wood County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his wife, four daughters and three sons.

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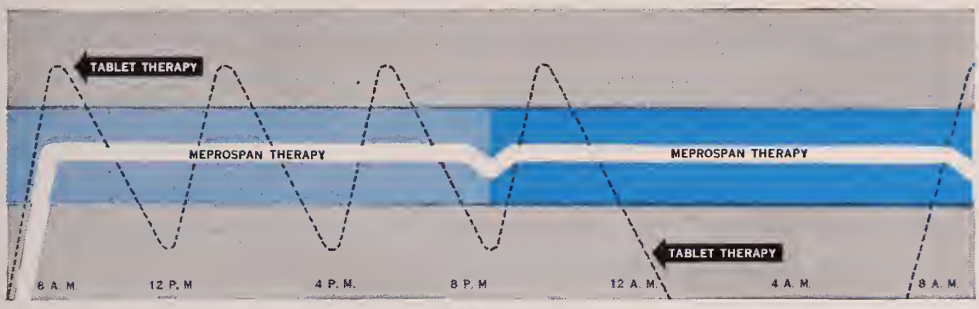

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News Items and Personals*

Green Bay Gets Anesthesiologist

Having recently completed two years of residency training at University of Wisconsin Medical School, *Dr. Frederick D. Cook* announced that he will serve three Green Bay hospitals in the capacity of anesthesiologist. He is the first specialist in this field to locate in the city.

Prior to beginning the residency, Doctor Cook practiced general medicine for eight years in Chippewa Falls and Menomonie. He graduated from the University of Wisconsin Medical School in 1947, serving during that time in a specialized program for the U. S. Army.

Casco Plans a Clinic

Plans are being made to erect and equip a $50,000 Casco clinic building with which to attract a doctor to serve the medical needs of the community. There is no doctor in the Village of Casco now.

If the desired goal is successfully reached, it will mean an average contribution of about $400 for each of the 130 families in the area. Funds to build the clinic will be raised by the sale of shares in the Casco Development Corporation and through memorial gift donations.

Dr. K. A. Forbes Begins Practice in Green Bay

A 1947 graduate of the St. Louis University School of Medicine, *Dr. K. A. Forbes*, has opened offices in Green Bay for the practice of urology. Following graduation from medical school, Doctor Forbes interned at St. Louis University Hospital, served a residency at the Deans' Committee Veterans Administration Hospital of Washington University, St. Louis, and St. Louis University Schools of Medicine, and spent two years in the U. S. Army Medical Corps. Since his discharge from service he had been practicing in East Orange, New Jersey. Doctor Forbes is certified by the American Board of Urology, is a Fellow of the International College of Surgeons and is a candidate for Fellowship in the American College of Surgeons.

* Physicians whose names are printed in italics are members of the Society.

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Doctor Hutter Receives Committee Appointment

In May Governor Vernon Thomson named *Dr. Adolph M. Hutter* of Fond du Lac to the planning committee of the second governor's conference on aging. The conference, which was held June 4–5 on the University of Wisconsin campus, was designed to explore opportunities for participation and service in community affairs by the older citizens.

Woman Named Chief of Racine Hospital

Dr. Beatrice O. Jones was elected chief of staff at St. Luke's Hospital in Racine. Doctor Jones has been practicing as a pediatrician in that city since 1933. During that time she has served as the first woman president of the Racine County Medical Society, the first woman president of the Racine board of education, and is now the first woman chief of staff at St. Luke's Hospital.

Doctor Kelley Attends Pathology School

Dr. Orville R. Kelley, Wausau, was among 60 clinical pathologists who attended a five-day workshop sponsored by the New England Society of Pathologists held in April at Boston, Massachusetts. Classwork at the school included instruction in basic spectrophotometry, practical electronics, blood pH methodology and photogluorimetry.

Third Generation of Karstens to Serve Horicon Citizens

After July 1 Dr. Fred Karsten will associate with his father, *Dr. John Karsten*, in the practice of general medicine. Doctor Fred received his medical degree from Marquette University School of Medicine in 1957 and is presently interning at Methodist Hospital in Madison.

The senior Doctor Karsten has served the Horicon community for the past 35 years, having taken over the practice of his father after his death in 1922.

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Cancer Films Shown in DePere During April

"Time and Two Women" and "Breast Self-Examination" were shown in DePere for the purpose of presenting in understandable terms two most common causes of cancer in women and stressing early detection of conditions which may result in cancer. This cancer education program, one of three public health projects given in DePere in April, was sponsored by the Brown County Medical Society. *Dr. Leonard C. Miller*, chairman of the Society's cancer committee, explained, "Early diagnosis of cancer is one of the greatest problems in public health today because it is the most important factor in the successful treatment of any kind of cancer regardless of whether it may be radium, x-ray, surgery, or a combination of all."

Dr. Rosekrans Was Elected to Head Medical Alliance

Dr. Sarah D. Rosekrans of Neillsville was recently installed for a two year term as president of the Pan American Medical Women's Alliance. The ceremonies took place in Miami, Florida.

The purpose of the Alliance is to further better understanding among the countries represented in the group which include those in North, South and Central America.

Rio Gets New Doctor

Dr. Harold M. Grundset was welcomed into the Rio area by the Community Club at a meeting held in his honor in May. He had been practicing in Green Bay before locating in Rio, which had been without a physician for a number of months.

The goal of the city is to provide a new medical center for the doctor. In support of this idea, *Dr. Dowe Cupery* of Markesan was the main speaker during the program. He described how a medical service building was constructed in his community after he established there. He also outlined how the citizens can cooperate with their doctor to the advantage of all.

Dr. Weihe Studies in Illinois

A clinic on traumatic orthopedic surgery at Northwestern University Hospital, Evanston, Illinois, was attended by *Dr. Arthur Weihe*, Adams, in April. The 7-day session featured studies on the best techniques for surgery on severe accident cases involving limb injuries and shock.

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Physical Medicine
Speech Therapy
Occupational Therapy
Vocational Counseling
Therapeutic Recreation

Emergency Preparedness Program Held in Beloit

An explanation of the facilities available at the Beloit Hospital in the event of a disaster was given by *Drs. Joseph Springberg* and *Richard Thayer* before a meeting of the Red Cross advance standing disaster preparedness committee in May. Following the talks the members outlined the programs of the Red Cross and the local hospital, discussing how cooperation and combined efforts in their functions would provide the most efficient service to the area.

Rib Lake Clinic to Get Doctor

The Rib Lake clinic committee announced in April that their new clinic building will be occupied by *Dr. Robert I. Pettera* in late summer. He is presently completing a one-year residency at St. Mary's Hospital, Milwaukee, where he also served his internship. Doctor Pettera, a native of Prairie du Sac, graduated from Marquette University School of Medicine in 1956.

Dr. Sanford Accepts Pittsburgh Position

Dr. L. L. Sanford began duties as senior physician in the Chest Disease Clinic of the U. S. Veterans Administration in Pittsburg, Pennsylvania, on May 15. He sold his two-year-old Hillsboro clinic building to *Dr. T. E. Boston.*

Doctor Sanford had practiced in Hillsboro for the past twelve years, having served prior to that time as resident physician at the Student Health Center at the University of Wisconsin and director of Student Health at the University of Wyoming. He was also on the staff of the Wisconsin State Sanitorium at Wales and on the medical staff of Milwaukee County Institutions.

Kenosha Hospital Honors Medical Staff

The active medical staff of St. Catherine Hospital in Kenosha, composed of 45 doctors, was feted with a dinner and program in May. *Dr. Robert C. Parkin,* assistant dean of the University of Wisconsin Medical School, was the guest speaker, lecturing on "Medical Education Today."

THIRD AND TWELFTH DISTRICTS NEWS

Milwaukee Physicians Win Exhibit Prize

Drs. J. W. Pick and *C. R. Marquardt,* of Milwaukee, won first place for their exhibit, "The Use of Miniature Film (Renogram) for Kidney Stone Surgery", at the American Urological Meeting in New Orleans in May. They also presented this display at the State Medical Society convention in Milwaukee.

(Continued on page 68)

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4 or more, each	3.46			3.17
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4 or more, each	4.56	4.56	3.83	4.15

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- **Highly potent and long acting.**[2,3,4,6,7,8]
- **Relatively free of adverse side effects.**[1,2,3,6]
- **In ordinary dosage does not reduce normal muscle strength or reflex activity.**[6]

Summary of four published clinical stu

ROBAXIN BENEFICIAL IN 95.6% OF CAS

CONDITION	NO PATIE
STUDY 1[1]	
Skeletal muscle spasm secondary to acute trauma	33
STUDY 2[2]	
Herniated disc	39
Ligamentous strains	8
Torticollis	3
Whiplash injury	3
Contusions, fractures, and muscle soreness due to accidents	5
STUDY 3[5]	
Herniated disc	8
Acute fibromyositis	8
Torticollis	1
STUDY 4[6]	
Pyramidal tract and acute myalgic disorders	30
TOTALS	138

ACUTE SKELETAL MUSCLE SPASM[1,2,5,6]

RESPONSE			
"marked"	moderate	slight	none
26	6	1	—
ronounced"			
25	13	—	1
4	4	—	—
3	—	—	—
2	1	—	—
3	2	—	—
excellent"			
6	2	—	—
8	—	—	—
—	—	1	—
ignificant"			
27	—	2	1
104	28	4	2
(75.3%)	(20.3%)		

Comments on Robaxin by investigators

THE JOURNAL
American Medical Association

"In the author's clinical experience, methocarbamol has afforded greater relief of muscle spasm and pain for a longer period of time without undesirable side effects or toxic reactions than any other commonly used relaxants . . ."[2]

THE JOURNAL
American Medical Association

"An excellent result, following methocarbamol administration, was obtained in all patients with acute skeletal muscle spasm."[5]

THE JOURNAL
American Medical Association

"In no instance was there any significant reduction in voluntary strength or intensity of simple reflexes."[6]

Southern Medical Journal

"This study has demonstrated that methocarbamol (Robaxin) is a superior skeletal muscle relaxant in acute orthopedic conditions."[1]

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References: 1. Carpenter, E. B.: Southern Medical Journal 51:627, 1958. 2. Forsyth, H. F., J.A.M.A. 167:163, 1958. 3. Little, J. M., and Truitt, E. B., Jr., J. Pharm. & Exper. Therap. 119:161, 1957. 4. Morgan, A. M., Truitt, E. B., Jr., and Little, J. M.: J. Am. Pharm. Assn., Sci. Ed. 46:374, 1957. 5. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:160, 1958. 6. Park, H. W.: J.A.M.A. 167:168, 1958. 7. Truitt, E. B., Jr., and Patterson, R. B., Proc. Soc. Exper. Biol. & Med. 95:422, 1957. 8. Truitt, E. B., Jr., Patterson, R. B., Morgan, A. M., and Little, J. M., J. Pharm. & Exper. Therap. 119:189, 1957.

Robins

(Continued from page 65)

Doctor Curreri Talks

"Recent Developments in Cancer Research" was the theme of two talks presented by *Dr. Anthony Curreri*, director of the Cancer Research hospital and professor of surgery at the University of Wisconsin Medical School. His speeches were delivered during April at the annual banquet of the Wisconsin State Nurses Association held in Madison and at a meeting of the Outagamie County unit of the American Cancer Society.

Dr. O. A. Sander Elected President of TB Group

A Fox Point physician, *Dr. O. A. Sander* was named head of the Wisconsin Anti-Tuberculosis Association. *Dr. J. M. Wilkie*, Madison, was also named as one of the new board members for the organization.

Doctor Gordon Guest of Chicago Medical Society

"The Metabolic Pattern of Atherosclerosis" was the title of a lecture given by *Dr. Edgar S. Gordon*, Department of Medicine at the University of Wisconsin Medical School. This was presented at a postgraduate course sponsored by the Chicago Medical Society at Chicago during March.

Forum on Arthritis Given in May

The Wisconsin chapter of the Arthritis & Rheumatism Foundation and the Milwaukee Junior Chamber of Commerce were co-sponsors of a forum, "Recent Advances in the Care of Arthritis", held at Marquette University on May 15. Speakers on the program were: *Drs. Edwin C. Welsh*, director of the department of physical medicine and rehabilitation at Columbia and St. Luke's Hospitals, Milwaukee; Mary W. Garry, chief of medical services of the Veterans Administration Hospital, Wood; and Peter L. Carnesale, chief of the orthopedic service at Wood.

Dr. H. E. Cook Is County Hospital Director

Dr. Harold E. Cook, Milwaukee, recently accepted the position of director of medical services of Milwaukee county hospitals and institutions under the jurisdiction of the board of public welfare. In addition to having a private practice in Milwaukee, Doctor Cook has served as medical director of the county dispensary–emergency unit on a part-time basis since 1949, was chief of staff of Deaconess Hospital from 1952 to 1954, and is a faculty member of the Marquette University School of Medicine. He is also division director of medical-hospital services of the Milwaukee metropolitan civil defense commission.

(Continued on page 70)

Clinical Conference

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(Continued from page 68)

Milwaukee Woman's Club Hears Doctor Costello

Appearing as a representative of the Medical Society of Milwaukee, *Dr. Addis C. Costello*, addressed the Milwaukee Woman's Club at its March meeting. His talk, centering around medical quackery in the field of cancer, emphasized the fact that about $10,000,000 is spent by cancer victims alone on the "quack". A great deal of this is spent, he said, by patients seeking out a doctor who will give them the diagnosis they want—others choosing quackery above the possibility of surgery. He further stated that there are no secret formulas and no guarantees among ethical doctors. A "quack" many times is detectable by his practices in the reverse of this.

Dr. Hans H. Reese Honored

Recently *Dr. Hans H. Reese*, neurologist at the University of Wisconsin, was elected to the Council of Medical Physics of the American Medical Association for a five-year term.

Doctor Reese was also given recognition for work done for the National Multiple Sclerosis Society when a Golden Key of that organization was presented to him.

Doctor Angevine Attends Meeting, Presents Paper

Dr. D. Murray Angevine, pathologist at the University of Wisconsin Medical School, attended the meeting of the American Association of Pathologists and Bacteriologists in Cleveland, Ohio, April 24–26, as a councilor to that society. In addition, he was invited to present a paper on, "Repair and Regeneration on Bone", in connection with a symposium on the Pathologic Physiology and Pathology of Bone, being sponsored by the International Academy of Pathology.

Dr. Ralph Campbell Lectures

During the month of March *Dr. Ralph Campbell*, Madison, attended a meeting of the American Association of Obstetricians and Gynecologists in Washington, D. C. He also presented two papers at a symposium on cancer at the section meeting of the American College of Surgeons in Salt Lake City, Utah.

Lecture on Childbirth Given in Madison

A pediatrician from the Quisling clinic, *Dr. W. H. Ylitalo*, delivered one of the free lectures sponsored by the Madison Association for Childbirth Education. He chose, "Understanding Your Infant", as the topic of his talk given in April.

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John E. Leach, M. D.
Lloyd F. Jenk, M. D.
Richard O. Barnes, M. D.
John R. Whitty, M. D.

Preston W. Thomas, M. D.

Doctor Messer Addresses Med Technicians

Dr. James W. Messer of the Jackson Clinic, Madison, was the main speaker at the Southern Wisconsin Medical Technicians Association meeting held in Madison in May. Doctor Messer discussed recent advances in the clinical treatment of diabetes. He is a member of the American Diabetes Association.

Doctor Bowers Given Post

President Eisenhower has appointed *Dr. John Z. Bowers*, dean of the University of Wisconsin Medical School, to the National Advisory Committee on Selection of Physicians, Dentists and Allied Specialists. Doctor Bowers attended a meeting of the committee on March 28 in Washington, D.C.

St. Croix Valley Memorial Hospital Adds Four Specialists to Staff

The board of directors of the St. Croix Valley Memorial Hospital recently announced the addition of four specialists—Drs. L. D. Harris, F. M. Walsh, M. P. Reiser, and D. E. DeRouf—to the staff. Doctors Harris and Walsh are eye specialists, Doctor Reiser's specialty is urology, and Doctor DeRouf is a specialist in internal medicine. All four of the physicians practice in the Minneapolis–St. Paul area.

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Basic Principles in General Surgery, Two Weeks, July 7
International College of Surgeons General Surgery Course, Two Weeks, July 7
Surgical Pathology, Two and Four Weeks, by appointment

GYNECOLOGY—Vaginal Approach to Pelvic Surgery, One Week, July 14

FRACTURES—Clinical Course, Two Weeks, by appointment

PEDIATRICS—Clinical Course, Two Weeks, by appointment
Neuromuscular Disease of Cerebral Palsy, Two Weeks, July 7

RADIOLOGY—Clinical Diagnostic X-Ray, Two Weeks, by appointment

UROLOGY—Cystoscopy, Ten-Day Practical Course, by appointment

DERMATOLOGY—Clinical Course, by appointment

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Society Records

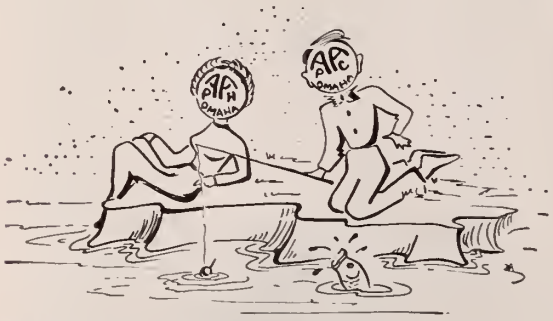
New Members

K. H. Neldner, 143 Main Street, Menomonie.
J. L. Nolan, Jr., Red Cedar Clinic, Menomonie.
J. E. Charles, 214 East Division St., Fond du Lac.
B. E. Liewen, 80 Sheboygan Street, Fond du Lac.
R. R. Roberts,** 407 N. Spring St., Beaver Dam.
D. J. Cohen, 3954 North 93rd Street, Milwaukee.
G. W. Poindexter, Veterans Administration Hospital, Wood.
B. F. Shockley, Jr., 2564 N. 66th St., Milwaukee.
R. L. Pettera, 5443 North Long Island Drive, Milwaukee.
R. L. Ruehl, 8317 West Lisbon Avenue, Milwaukee.
H. I. Singer, 211 North 110th Place, Milwaukee.
J. P. Paulissen, Milwaukee Children's Hospital, Milwaukee.
J. C. Devine, 161 West Wisconsin Avenue, Milwaukee.
L. K. Mark, Mount Sinai Hospital, Milwaukee.
E. F. Wallner, 1714 East Capitol Dr., Milwaukee.
J. Y. P. Chen, 561 North 15th Street, Milwaukee.
A. M. Kinkella, 650 South Central Ave., Marshfield.
W. N. Otterson, Viroqua.
D. U. Cookson, 145 Craig Avenue, Madison.
H. E. Gaspar, 1300 University Avenue, Madison.
H. W. Roberts, 25 Harding Street, Madison.
J. W. Messer, Jackson Clinic, Madison.
C. D. Sargeant, Manitowoc.
H. M. Grundset, 610 Northern Bldg., Green Bay.
C. W. Yellick, 3208–A North 29th Street, Milwaukee.
Salvatore Fricano, 2229–A South Winchester Street, Milwaukee.
E. H. Barnes, III, 520–58th Street, Kenosha.

** Reinstated member.

Changes of Address

W. H. Costello, Beaver Dam, to 733 West Windsor Avenue, Phoenix, Arizona.
F. J. Gillette, Mondovi, to 902 Foster Street, Marlin, Texas.
B. D. Kohne, Milwaukee, to 4350 41 Street, No. 5, San Diego, California.
D. C. Hampel,** Vallejo, California, to Mobile Construction Battalion No. 11, % SPO San Francisco, California.
L. W. Kipke, Milwaukee, to 2823 Northeast 26th Place, Fort Lauderdale, Florida.
W. O. Sydow, Milwaukee, to 2005 Underwood Avenue, Wauwatosa.
T. D. Foster, Takoma Park, Maryland, to 1811 East Truman Avenue, Eau Claire.
R. B. Goodfriend, ** Peshtigo, to 318 East 23rd Street, New York, New York.
H. N. Heinz, Sheboygan, to Box 246, Taylor Falls, Minnesota.
C. H. Mahaffey, Superior, to V. A. Hospital, Wood.
D. R. Schumacher, Appleton, to Tucker Building, Clinton, Iowa.
M. E. Solberg, Milwaukee, to Viola.
R. P. Bowles, Edgerton, to 114 North Water Street, Liberty, Missouri.
H. J. Lodge, Madison, to 306 Vanderbilt Hall, Boston 15, Massachusetts.
R. F. Gosin,** Buffalo, New York, to 351 Pasadena Avenue. South Pasadena, California.
R. C. Zastrow,** Milwaukee, to U. S. Naval Hospital, Bremerton, Washington.



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THIRD ANNUAL VOLUME OF THE BIBLIOGRAPHY OF MEDICAL REVIEWS AVAILABLE IN JUNE

Seymour I. Taine, assistant librarian for indexing of the National Library of Medicine, has announced the publication in June of the third annual volume of the *Bibliography of Medical Reviews.*

Included in Volume 3 are approximately 600 non-*Current List* articles along with the 2300 review articles also listed in the *Current List.*

The 1958 volume of the *Bibliography of Medical Reviews* is arranged by subject with a separate author index and contains approximately 2900 references to review articles in clinical and experimental medicine and allied fields which have appeared largely in 1957. Copies of Volume 3 for 1958 are available from the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C., at a price presently estimated at $1.25.

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1. Weinberg, A., and Werner, W. E. F.: Am. Pract. & Digest Treat. 6:580 (April) 1955.
2. Codling, J. W., and Lowden, R. J.: Northwest Med. 57:331 (March) 1958.

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RECENT WISCONSIN LICENTIATES

The following physicians were granted licenses by reciprocity by the State Board of Medical Examiners at a meeting in Madison, April 25, 1958:

Name	*School of Graduation*	*Year*	*City*
Anderson, E. M.	University of Minnesota	1935	La Crosse
Babb, J. L.	Ohio State University	1950	San Antonio, Texas
Bowerman, C. I.	University of Rochester	1952	Marshfield
Drvaric, E. J.	Harvard Medical School	1953	Milwaukee
Fritz, R. D.	University of Wisconsin	1954	Baltimore, Maryland
Furr, L. O.	St. Louis University	1953	River Falls
Gandy, T. I.	Howard University	1929	Hastings–on–Hudson, New York
Gerstle, W. J.	University of Heidelberg	1938	Buffalo, New York
Grinvalsky, H. T.	New York University	1946	Stevens Point
Grundset, H. M.	College of Medical Evangelists	1955	Rio
Kretzschmar, W. A.	University of Michigan	1951	Milwaukee
Landis, C. W.	Indiana University	1951	Milwaukee
Lucas, L. A.	University of Bern	1951	Madison
Olsen, B. J.	Marquette University	1954	Iowa City, Iowa
Preizler, Josef	University of Vienna	1936	Madison
Sachs, J. S.	University of Geneva	1954	Milwaukee
Schumacher, G. F.	Marquette University	1954	Madison
Scott, J. K.	Ohio State University	1954	Madison
Temple, C. O.	Chicago Medical School	1937	Chicago, Illinois
Thorgersen, T. M.	Marquette University	1953	Wausau
Unger, Abraham	Anderson Medical College	1939	Cleveland, Ohio
Voss, E. C., Jr.	University of Buffalo	1950	La Crosse
Weatherhogg, C. R.	University of Nebraska	1955	Madison

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Instead of the traditional three-day "circuits", the programs this academic year will be largely concentrated on Wednesdays and Thursdays, or on single days only, to better accommodate the large number of physicians who close their offices on specific days.

The programs will provide CATEGORY I credit for all members of the Wisconsin Academy of General Practice in attendance.

Program details are being arranged with representatives of the Wisconsin Academy of General Practice and the two medical schools. Complete information as to faculty, subjects and meeting sites will be provided members prior to August 1.

It is hoped that these meetings will be of service to our members, and that the registration will be adequate to provide similar instruction during 1959.

KENNETH E. LEMMER, M.D.
Chairman, Council on Scientific Work

TENTATIVE SCHEDULE—OCTOBER–NOVEMBER

(Meetings starred will have dinner and evening program: $5.00 for afternoon only and $8.00 for entire program.)

WEDNESDAY, OCTOBER 1: Eau Claire*
THURSDAY, OCTOBER 2: Wausau*
(Ninth Councilor District Meeting)

WEDNESDAY, OCTOBER 8: Janesville*
THURSDAY, OCTOBER 9: Appleton
THURSDAY, OCTOBER 16: Sheboygan
WEDNESDAY, OCTOBER 22: Marinette*
THURSDAY, OCTOBER 23: Rhinelander*
FRIDAY, OCTOBER 24: Superior
THURSDAY, OCTOBER 30: Madison
THURSDAY, NOVEMBER 20: Wisconsin Rapids

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PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 15th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from individual members of the State Medical Society will be accepted without charge. The charge quoted previously applies to advertisements placed by clinics. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.

INTERN DESIRED: Associate wanted in Central Wisconsin community of about 13,000. Address replies to Box 731 in care of the Journal.

OPPORTUNITY FOR ONE, preferably two, physicians in community near Madison, one story building to be constructed to house drug store, dental office and medical offices, parking side and rear of building; village development committee urging this building, eight miles to Madison Hospitals. Contact Box 730 in care of the Journal.

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LOCUM TENENS AVAILABLE: Wisconsin licensed physician available for one month during May, June or July to do general practice. Will need few day's notice. Now at University Hospitals, Madison. Address replies to Box 727 in care of the Journal.

LOCUM TENENS: Resident in surgery desires locum tenens for two months (July and August) to do general practice and surgery. Contact Theodore S. Roberts, M.D., University of Wisconsin General Hospital, Madison, Wisconsin.

WANTED: Young, white, male M.D. for surgical assistant and also general practice in 16 man medical group. This is a one or two year appointment beginning July 1, 1958, and is a good opportunity to obtain training under qualified men. Write giving resume and salary expected to Midelfart Clinic, Eau Claire, Wisconsin.

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DOCTORS' OFFICE SPACE AVAILABLE in beautiful new Brentwood Medical Arts Building, 2018 North Sherman Avenue, Madison. Private doctors' parking, public parking (40 cars), acoustical ceiling, mahogany paneling, heat and air conditioning, large reception room, black top parking area, pharmacy in building. On bus line, convenient to schools and churches. Address replies to Box 715 in care of the Journal.

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E.N.T. man available for part or full time association with small group in and around the Milwaukee area. Contact Box 734, care of the Journal. m6-7

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LOCUM TENENS WANTED from July 23rd to Aug. 6, residence and car available. Please write to Harold J. Werbel, M.D., Delavan, Wisconsin. m6

THE WISCONSIN MEDICAL JOURNAL

Volume 57 JUNE 1958 Number 6

Message to the House of Delegates*

By J. W. FONS, M. D.

Milwaukee

TO BE selected to preside over the affairs of medicine in the State of Wisconsin is a great honor, and I realize even more fully now than a year ago the importance of doing justice to the requirements. You honored me, though I lay recuperating in the hospital; but I hope to recompense the Society in the days ahead, for I am a firm believer that it is better to give than to receive.

The addresses that custom has established for this occasion have covered every conceivable subject. Some have been grave and others, though not frivolous, less grave. Some have been learned, others perhaps more ordinary. Some have been highly technical while others have been given to general considerations.

I certainly shall attempt nothing grave nor learned. Even if I were capable of preparing and serving a profound discourse, it would not be right to dull the pleasing taste of Doctor Kasten's message by presenting you with a second dessert.

So it occurs to me to limit my remarks to simple expressions of what seem to be important matters for our profession.

Every age, every year, every month—even every day—has its problems. Sufficient unto the day is the evil thereof, and I might add, the good. We cannot become preoccupied with a single current problem—medicine has too many elements, it has too much of the noble play about it to narrow its sights for long. Nor can we turn our backs on the past and live only in the future. There is need to recognize that while we plan for the future we must concentrate on the work at hand.

These are simple basic truths with which every physician must find acquaintance. And there is at least one more—perhaps the most significant for us as doctors of medicine:

Since time immemorial people have found that they can best serve themselves and their responsibilities to others by doing many things collectively rather than individually. It is important for us to realize that physicians, for all their individualism, have applied themselves to this principle with amazing fervor. They have done many things collectively through their county and state medical societies which they could never have done as individuals. In doing so they have better served themselves and the people of Wisconsin.

MEDICINE—A LIFE OF STUDY

Let me call your attention to the Medical Society as a study group. There certainly is no other profession which entails a life of study as does the profession of medicine. The work of the modern physician has become the most involved of any of the arts that men ply with their hands and heads. The well informed general practitioner must be almost myriad-minded to hold the essential facts of anatomy, physiology, pathology, bacteriology, chemistry, pharmacology and the still more technical facts which are corolary to these sciences in surgery, orthopedics, internal medicine and the other specialties. The medical man fools himself who thinks his school knowledge will stand him in stead for any great length of time. He who is not willing to join in lock step and become a student-practitioner will be dropped from the ranks to become something which was but is not.

How vital the work of your State Medical Society to cultivate the spirit of the teacher and the study class! The grand array of

* Presented before the House of Delegates, One Hundred Seventeenth Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, May 5, 1958.

scientific knowledge unfolding at this very meeting—as it has done for more than a century—is nothing short of spectacular in its impact for better medical care. Nearly half of the practicing physicians of Wisconsin will partake of this giant study class in the short span of the next three days.

Yet, this is but a fraction of the total teaching effort of your Society. The circuit clinics, literally bringing the teacher to the student, reach out to at least 30 per cent of the practicing men in the areas served. Four maternal mortality institutes since January have brought special knowledge to more than 300 practitioners. The Wisconsin Medical Journal provides a monthly injection of scientific knowledge as essential to continued medical mental health as insulin is to the diabetic.

None of these—the annual meeting, the clinics, the special studies, the Journal—could be implemented by the lone physician. They are the product of a professional organization.

ALL WISCONSIN BENEFITS

Likewise, public health has felt and profited by the strength of the collective effort of the medical man through his State Medical Society. Wisconsin owes much to the organized effort of physicians for its medical schools, its mental health institutions, its schools for the blind and the deaf, its licensing of physicians, its protection from quackery, its public health system, its tuberculosis control, its infirmaries for the aged. The list is but barely begun. You have only to turn to your Delegates Handbook and the reports of the Commission on State Departments to see the vast area of contact with public health matters which your Society carries on today. Without the collective efforts of the members through the Society how could sound school health programs have been applied to all of Wisconsin?

How could free choice of physician have been assured the public assistance recipient?

Who would have established visual and hearing standards for Wisconsin drivers, especially school bus drivers?

Would tuberculosis be under control as it is; would examination of school employees be compulsory for the protection of our children—and how would those examinations be conducted?

Would Wisconsin have earned its current enviable reputation in maternal and infant mortality without close medical society and board of health cooperation?

Would those who are mentally ill still be handled as criminals?

Would commitment proceedings still be archaic and unjust?

And without the collective efforts of the profession in the legislature would Wisconsin today find

. . . Its medical schools shackled by antivivisection laws?

. . . its health menaced by unprincipled quacks and untrained practitioners?

. . . its state health programs directed by non-medical personnel rather than by physicians?

Then turn to economic medicine for a moment. Nearly 800,000 Wisconsin people have their insurance for physicians' services through the mechanism of county and state medical society programs. How else could the public have been assured of such high quality benefits? How else could physicians have had their voice in the establishment of fair and inclusive fee schedules? How else could the people of Wisconsin and the medical profession now claim preeminence in the development of catastrophic coverage and the "reasonable charge" concept.

Would anyone be so naive as to believe the federal government would suggest, much less implement, its Medicare program with a form of the no-fee-schedule contract?

And what bureaucratic turn would veterans' care have taken had not Wisconsin held tenaciously to the Home Town Care program administered by the State Medical Society?

PROGRESS ASTONISHING

The progress physicians have made in providing protection for surgical-medical services is really astonishing considering that only 15 years have passed since the inception of these projects. Several features distinguish this Society effort in Wisconsin —the patient's right to free choice of practitioner, the emphasis on patient care rather than administrative detail, and constant effort to secure "full service coverage" and reasonable physician reimbursement for services rendered.

There are some within our ranks who are critical of "the doctors' plans"—Blue Shield. Some say the benefit for removal of ingrown toenails is not enough. Some say we ought to provide coverage for home calls. Some want deductible programs. Everyone abhors the paper work. To these men may I say just a few words. Sound physicians' care plans are not the product of spontaneous generation any more than is typhoid bacillus. In this state, at least, they owe their good health and growth to constant nurturing by dedicated men on their operating committee and Commission on Medical Care Plans. Thousands of hours of unreimbursed attention have been given to Medicare, Wisconsin Physicians Service and Surgical Care by members of your Society. These men have been impressed with the urgency of providing the public with adequate health protection at reasonable cost. At the same time they have developed mechanisms to provide the physician with the greatest possible freedom to practice the type of medicine which best fits the needs of his patient as well as providing the patient with free choice of physician.

That is a task in which hundreds, if not thousands, of Wisconsin physicians have participated with great success.

If the Blue Shield plans of today are not all they might be, physicians should not be surprised. The elusive character of perfection is only too well known to the physician and this is as true of the economic side of medicine as it is of the scientific. Physician, and patients, must realize that health insurance plans do not spring de novo, full grown and potent like Minerva from the brow of Jove.

I am reminded of the words of Sir Oliver Lodge. "To be scientific," he said, "does not mean to be infallible, but it means being clear and honest, and as exact as we know how to be. In difficult investigations, pioneers have always made some mistakes; they have no immediate criterion or infallible touchstone to distinguish the more true from the less true, but if they record their results with anxious care and scrupulous honesty and painstaking precision, their mistakes are only less valuable to the next generation than their partially true generalizations.

"Sometimes it turns out after a century or so, that mistakes made by early pioneers were not such thorough errors as had been thought, that they had an element of truth in them all the time, as if discoverers were endowed with a kind of prophetic insight whereby they dimly glimpsed theories and truths which it would take several generations of workers to disencumber and bring to light."

The comments of Sir Oliver Lodge are particularly applicable to our economic developments in the field of prepaid plans. Physicians in Wisconsin can say that they have done their collective best, and it must be some credit to them that their effort has contributed to a growth in health insurance that is regarded everywhere as an economic phenomenon.

A GREAT FOUNDATION

In quite a different vein but with the same purpose, I would like to speak for a moment of one of the finest programs of our Wisconsin profession—one that will certainly someday be recorded as our greatest collective effort. I speak of the Society's Charitable, Educational, and Scientific Foundation.

How many of you know the great personal tragedy that has befallen some of our colleagues? Without money, plagued by a disease or infirmity, and sometimes without friends, there are some of our own—more than you think—who need your helping hand. I can think of no finer way by which we can take care of our own than through the Foundation of the State Medical Society.

This Foundation also offers unlimited opportunity to support postgraduate education and research. We have only to channel toward it some of the resources of voluntary agencies and private concerns, as well as our own contributions, and we will have mustered a potent force for postgraduate education in Wisconsin.

The student loan fund—already aiding nearly 40 medical students of both medical schools—is only beginning to realize its capabilities. The Wisconsin Museum of Medical History is on the verge of becoming one of our greatest educational tools—a living development of the scientific perspective of equal value to physicians and the public.

DR. NICHOLAS SENN

And while I speak of history, I should like to make a personal comment. This year marks the 50th anniversary of the death of a great Wisconsin physician, Dr. Nicholas

Senn. This renowned surgeon who became the 49th president of the American Medical Association lived and practiced in Fond du Lac, Ashland, and Milwaukee before his amphitheater clinics became one of the attractions of medical Chicago. For many years he lived in Milwaukee and commuted to Chicago. The building which housed his office still stands at the corner of North Third Street and Juneau. Interestingly enough, his remarkable zeal for surgical pathology was developed in a laboratory constructed under the sidewalk leading to his office. Here, night after night, he carried on his original investigations from which he made significant contributions to abdominal surgery. I would like to propose that our Foundation and the Section on Medical History collaborate in placing a suitable marker in a prominent place before this building so that all who pass by might know the works of one of our great colleagues.

Ladies and gentlemen, I think you can see why I have emphasized the importance of working together for our professional good and the public well-being. We have achieved a great deal through our state Society that we could never have done individually, or for that matter as separate county societies. Yet, there is one important area of collective effort that today cries for attention. As physicians we realize the enormous achievements of scientific and economic medicine. That the general public does not have this appreciation is acutely apparent.

PUBLIC NEEDS TO BE INFORMED

Collectively we need to channel a supreme effort of time and energy into a new type of public health education. Here are some of the things we need to tell the public:

. . . what is medicine?
. . . what are its requirements?
. . . what is quackery?
. . . why the standards for hospital accreditation?
. . . what is the generalist, who is the specialist, and how do they work together?
. . . who are the ancillary personnel in the health field and what are their requirements?
. . . what is public health and what has the private practice of medicine contributed to it?
. . . what are the true costs of "health care" and what part of these costs is the physician's responsibility?

This is a substantial program and one of tremendous significance for the future of the medical profession. This is a long range plan which must become crystalized within the next two years if we are to turn the tide of public criticism and misunderstanding.

Lack of instruction from proper sources is responsible for many of the fads and fancies which are promulgated from time to time as a panacea. Critics expect medicine to be an exact science; they say that we as practitioners sometimes make mistakes, that we are often emperical, that we have given too many drugs, and the like. Before we condemn the critic for his misdeeds, we must ask ourselves what would we do if we had his misinformation. We recognize that the ideal in medicine has not yet been achieved, but we also recognize that honest self-sacrificing effort to that end is being constantly pursued.

The critics do not realize that in many instances their very existence is due to advances in medical science. We have only to recall within our own time the elimination of smallpox, cholera, yellow fever, diphtheria, typhoid, and the mitigation of tuberculosis, polio, etc. To take pride in these achievements is not enough. The public must be informed of any and all advances accomplished by medical science. I earnestly request the House to consider the urgency of planning for a comprehensive public health education program at the earliest possible moment.

During the past few minutes I have attempted as best I could to impress upon you the significance of our collective efforts as physicians in organized medicine. I have attempted to reveal the value of the State Medical Society to its membership in the fields of scientific medicine, economic medicine, public health, legislation, and in its charitable and educational aspects. I hope I have impressed upon you the need for expanded emphasis upon public health education.

HARMONY WITH INDIVIDUALISM

But after all these things have been done which relate to professional and public education, we shall still not be wise unto salvation. I speak finally of espirit de corps. Our

Society has been the means, and I believe will continue to be the means, by which we may live and work together in harmony and to the benefit of the public as well as ourselves. If our Society brought us nothing, save an all enveloping concord and good will, sufficient reasons for its continuance would exist. The quarrels of physicians have been almost proverbial, being the individualists that they are. The houses of Montague and Capulet were not more militant at times than physicians have been.

> "Do you bite your thumb at us, sir,
> No, sir; I do not bite my thumb
> at you, sir, but I bite my thumb."
> (From Romeo and Juliet)

With as little rhyme or reason physicians, sometimes with imagined grievances, and armed with a hypertrophic jawbone, proceed to hew off noses. Nothing is gained save to curse our lives and to heap opprobrium upon the profession. Since earliest times physicians have been the subject of criticism and satire from would-be wits. Medical science certainly has its vulnerable Achilles heel where the shafts of satire can pierce. However, petty quarrels among physicians are detrimental to the dignity and usefulness of the profession.

I would hope that the day is not far distant when we will be able to leaven the dough of controversy and as a united profession focus our intent upon the real issues in our chosen field. It is in this higher scientific and ethical standing that the greatest good comes to the medical profession, to the individual physician, and to his patient.

PREPARATION OF MANUSCRIPTS FOR THE WISCONSIN MEDICAL JOURNAL

Exclusive Publication: Articles are accepted for publication on condition that they are contributed solely to this Journal. Publication elsewhere will be subsequently authorized in the discretion of the Medical Editor.

Correspondence: Address all correspondence relating to publication of scientific papers to the Medical Editor.

Manuscript: Type double spaced, on 20 pound white paper, 8½ by 11 with one inch margins at the top, bottom, and right, and 1½ inches on the left. Submit the original and two carbon copies. Use the metric system throughout. Call drugs by their generic names. The trade names can be added, in parenthesis, if they are considered important. Keep one copy of the paper.

Identification: Place the name of author and page number at the upper left-hand corner of each page except the first.

Footnotes and References: Use the style of the *Quarterly Cumulative Index Medicus* published by the American Medical Association, which requires, in the order given: name of author, title of article, name of periodical, with volume, pages, month—day of month if weekly—and year as follows:

> 4. Doe, J. E.: What I Know About It,
> Wis. Med. J. 54:717–719 (Dec.) 1954.

And, include only those references specifically referred to in the text.

Reprints: An order slip for reprints with a table covering cost will be sent with the galley proof to each contributor.

Illustrations: Four illustrations per article are allowed without cost to the author. Beyond this number the author must pay the actual cost of illustrations. Place the name of the author on the back of each illustration, table, etc. Submit clear and distinct 3 by 5 glossy photographs. Make drawings in black ink on white paper. Attach a slip of paper to the bottom of the illustration with the author's name, identification of article, and appropriate legend. Photographs and drawings will be returned if so requested.

Under ordinary circumstances articles are scheduled about six months in advance. The approximate date of publication, subject to change, will be given the contributor when the article has been accepted.

Society members throughout the state are encouraged to write up their interesting cases and submit them for publication. The editorial staff welcomes the opportunity of helping you prepare your article for the printer.

The Development of the Artery Bank at the University Hospitals*

By JOHN T. PHELAN, M.D.,** WILLIAM P. YOUNG, M.D., RICHARD J. BOTHAM, M.D., JOSEPH W. GALE, M.D., and ERWIN R. SCHMIDT, M.D.

Madison

THE recent increase in the use of arterial homografts in vascular surgery has made it desirable to establish an artery bank at the University Hospitals. In the past, difficulties in securing artery grafts by a sterile technique made such a development quite impractical. However, with the advent of newer methods of sterilizing biologic tissues, artery homografts are now removed from suitable subjects during a routine post mortem examination. In this regard, two agents have been employed for this purpose, namely: (1) ethylene oxide, and (2) betapropiolactone. We have selected betapropiolactone mainly due to its ease of handling (ethylene oxide is explosive), and from our experimental studies which compliment in many respects the original work of LoGrippo, *et al.*[1] who initially employed this agent in sterilizing contaminated artery homografts. In addition, reports from other institutions[2,3] have shown that betapropiolactone is highly satisfactory for this purpose. At present, the following procedure is used in securing and preserving artery homografts at the University artery bank.

SUBJECTS

Artery homografts are removed from subjects under the age of 50. In each instance, the arteries must be visibly free of any degenerative disease. In addition, a positive serology, a history of infectious hepatitis, or one of the collagenous diseases contraindicate their use for human application. Although we are hesitant to use artery homografts from individuals who have died from widespread tumor metastases, we are of the opinion that such grafts are suitable as long as tumor tissue has not invaded the artery wall.

METHOD OF PROCUREMENT

It has been found desirable to remove artery homografts for clinical application as soon as possible; however, with adequate refrigeration of the body, artery grafts can be obtained as long as 24 hours after death. As has been stated, the pathologist removes the aorta and its branches during his routine post mortem examination. The entire aorta, beginning just below the left subclavian artery down to and including both external iliac arteries, is removed. The aorta is placed in a glass container filled with Ringer's solution and refrigerated at 10 C. In this manner the graft can be stored for 12 hours without altering its functional integrity. The aorta is subsequently transferred to the artery bank and defatted by sharp dissection. Caution is exercised in leaving the individual branches sufficiently long so as to insure easy ligation by the surgeon subsequent to its application. The aorta is then divided into two segments at the level of the celiac artery and the lumens of both segments are irrigated with saline solution. The artery

Fig. 1—Preparation of the aorta and its branches prior to sterilization by betapropiolactone.

* From Department of Surgery, University Hospitals, and the Cardiovascular Research Department (Charles W. Crumpton, Director), Madison, Wisconsin.

** Director of Artery Bank.

Fig. 2—Artery homografts stored in special glass containers and available for use. The cloudy precipitate is the fibrin portion of the nutrient media.

homograft is then sterilized with betapropiolactone.

METHODS OF STERILIZATION AND PRESERVATION

Betapropiolactone in properly diluted solutions and measured pH is made according to the method of LoGrippo, *et al.*[1] The artery graft is immersed in this solution and incubated for three hours at 37 C., following which sterilization is complete. At this point, rigid sterile techniques are used in handling the grafts; hence, an ultra violet ray hood, caps, masks, and sterile instruments are employed. The artery homograft is transferred in a sterile fashion to special glass graduates to which is added Ringer's solution and 10 per cent plasma. The graft is contained in this solution at 4 C. for a period of four weeks. Bacteriologic studies are determined on this nutrient media at the end of 48 hours and recorded on the fourth day; and, if negative, a one per cent merthiolate solution is added to the media containing the artery homograft. Following this procedure, the artery homograft is available for use if the occasion arises. However, this method of preservation and storing is limited, as degenerative changes have been demonstrated in the elastic layer of the artery wall within four to six weeks. Because of this factor, the artery homografts remaining after this period are freeze-dried and lyophilized.

FREEZE-DRYING AND LYOPHILIZATION

The freeze-drying procedure consists essentially of rapidly freezing the artery homografts to –70 C., followed by drying or lyophilization under a high vacuum. In our method, the artery homograft is removed from the nutrient media and transferred in a sterile fashion to a large pyrex test tube. The test tube with the graft is immersed in a carbon dioxide-alcohol slush mixture at a temperature of –70 C. The principle behind such a rapid freezing method is based on the physical laws governing freezing, in that the available water is transferred to a crystal state. The size of the crystals is determined by the rapidity of the freezing process and the characteristics of the specimen. When

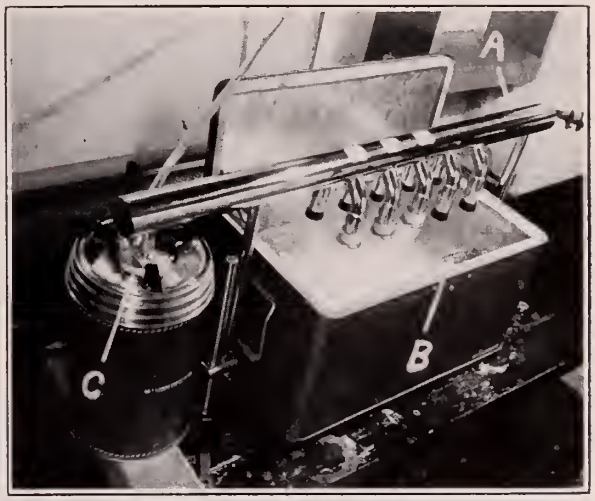

Fig. 3—Working mechanism of the freeze-drying apparatus. (Bethesda Units. Manufactured by J. Stokes Corporation, Philadelphia, Pa.). (a) the manifold with attached test tubes containing artery homografts submerged in a carbon-dioxide-alcohol ice bath at –70 C. (b) a wire basket, suggested by Mr. John Robertson, department of medical microbiology, which has alleviated the problem of rapidly freezing the grafts by permitting only a slush mixture to freeze the grafts and not the larger pieces of carbon dioxide ice. A large bulk of this slush mixture has been removed to demonstrate a part of the basket. (c) the condenser.

freezing is slow, the crystals that form are large and unevenly distributed throughout the specimen; however, with a high rate of freezing, the crystals are uniformly distributed and smaller in size. In respect to artery tissue, accelerated freezing is desired, as the crystal formation is such that distention and disruption of the artery wall is minimal.

The lyophilization, or drying process, is carried out under a vacuum from between 10 to 50 microns of mercury, which is ac-

hieved by an oil immersion pump. A specially constructed manifold with tube attachments and condenser is employed in this process. The test tube containing the frozen artery homograft is attached to the manifold and the desired vacuum is produced. During the first two hours of this process, the test tube containing the graft is maintained at –70 C. This is done to prevent the vessel from thawing which in itself would result in the formation of large crystals, and hence alter the architecture of the graft. However, once a high vacuum is achieved, the heat lost by sublimation of the ice crystals keeps the artery graft frozen; hence, after two hours, the carbon dioxide-alcohol slush bath is removed. The lyophilization process is maintained at the 10 to 50 micron pressure range for an additional 18 hours; during this time sublimation of the ice crystals is continuing so that at the end of this period the water content of the artery graft is less than 0.05 per cent. At the completion of the lyophilization process the glass test tube containing the artery homograft is sealed with a soft rubber stopper and the air removed via the vacuum pump. To determine the efficiency of the vacuum, an ionizing current is applied to the test tube which, if complete, produces a characteristic red color. Such an artery homograft can be stored at room temperature for periods up to as long as two years.

Whenever the occasion arises, the graft is removed and reconstituted in normal saline solution containing 500,000 units of penicillin and 0.5 gm. of streptomycin for 45 to 60 minutes. Some authors consider it advisable to immerse the test tube and artery homograft in the saline solution prior to removal of the graft, so as to prevent air from entering the interstices of the artery wall during its reconstitution. We have not found this procedure necessary.

Needless to say, the demand for artery homografts has in the past exceeded the supply. To date, this problem is still present; however, with the method of preservation just described, the problem has been alleviated to some degree. In addition, such artery homografts are readily available to hospitals unable to maintain an artery bank, as such grafts can be shipped from one place to another by commercial transportation without fear of contamination.

In addition to the organization of this artery bank by the surgery department of the

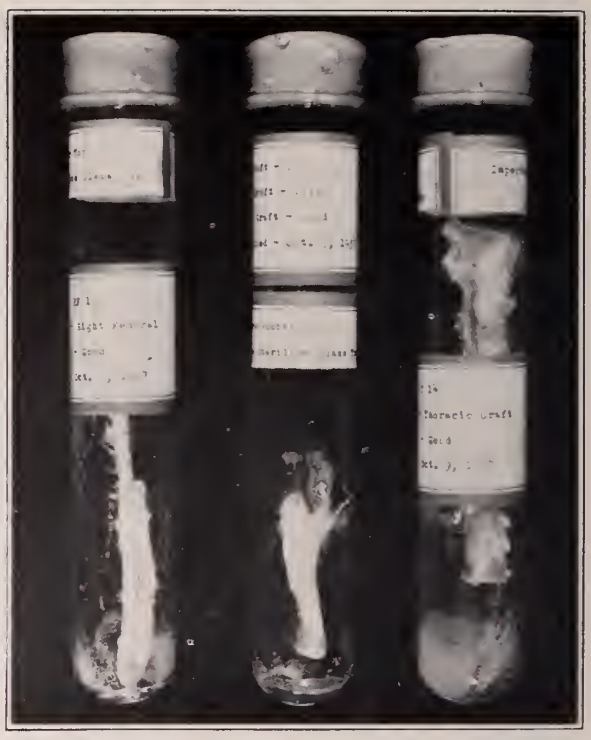

Fig. 4—Photograph showing the freeze-dried artery homografts in test tubes with labels indicating type of graft, grade of graft, and date of procurement.

University Hospitals, the close cooperation of the department of pathology (Dr. D. Murray Angevine), the pathology departments at St. Mary's Hospital (Dr. Edward A. Brucker) and Madison General Hospital (Dr. Phillip G. Piper), and the department of medical microbiology (Dr. Charles V. Seastone, Dr. Duard J. Walker and Miss Theo Wuebben) has made the function of this artery bank possible. In the early stages of the artery bank development the suggestions and help of Dr. Ned. Maxwell, chairman of the Milwaukee Artery Bank, and Dr. Eugene E. Skroch, department of surgery, the University Hospitals, Madison, is acknowledged. In addition, the majority of the funeral directors in the Madison area have given their complete approval for this project and have aided immeasurably in the procurement of these arteries. The technical assistance of Mrs. Lorraine Coanda has been greatly appreciated.

(J.T.P.) 1300 University Avenue.

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(Continued on page 248)

Report On Poison Control Centers Milwaukee County, 1956

By FRANKLIN J. MELLENCAMP, M. D.*
Milwaukee

INTRODUCTION

IN 1950 the increasing toll of accidental poisonings in children led the newly formed accident prevention committee of the American Academy of Pediatrics to point out the need for direct action. Subsequently, in 1953 plans for the establishment of a poison control program were developed in Chicago. Since the opening of the first centers in Chicago, over 100 centers have become active in this country. The Milwaukee program had its inception in 1955 under the direction of the subcommittee on accident prevention of The Medical Society of Milwaukee County.

The rapid growth of this program nationally has culminated in a plan for development of a national clearing house for poison control centers under the Department of Health, Education and Welfare.

Five hospitals** participate as treatment and information centers in Milwaukee County. Reports were forwarded to the vital statistics division of the Milwaukee Health Department for coding and statistical analysis.***

ANALYSIS

1. *Incidence by Agent*—Drugs constitute 55 per cent of the ingested toxic substances. Epidemiologically, it is interesting to note that this is the trend in urban centers. Acetylsalicylic acid and methyl salicylate (oil of Wintergreen) numerically present the greatest hazard. Sedatives, including barbiturates and tranquilizers, also are significantly frequent. These two constitute 43 per cent of all cases involving accidental drug poisonings.

Household agents constitute 45 per cent of the substances ingested. Corrosives and caustics, petroleum distillates, pesticides and arsenic compounds, industrial solvents and alcohol account for 25 per cent of the total cases reported as caused by household agents.

2. *Age*—Seventy-four per cent occurred in the ages one, two, and three.

3. *Time*—There was only slight concentration of ingestions, the time being between 10:00 a.m. and noon. Twenty-four cases occurring between midnight and 5:00 a.m. were adults, the chief agent being sedatives.

4. *Location*—Where substances were found and ingested: kitchen–183, bedroom–121, bathroom–117, living room–43, basement–19, pantry–14, outside of home–32.

5. *Elapsed Time Before Treatment*

30 minutes	31%
60 minutes	65%
80 minutes	80%

6. *Fatalities*—There were nine fatalities. Of the three among children, there was one caused by antihistamine, one by lead, and one by gas inhalation. Among six adults, three were due to gas inhalation and one each by barbiturates, carbon tetrachloride, and dilaudid intoxication.

COMMENTS

In the metropolitan area of Milwaukee, 826 poisoning cases were treated in the poison control centers. I believe it safe to venture that several times that number were advised and treated in physicians' offices and other hospitals in the community. Improved reporting methods would present a more accurate picture of the problem. It is probably true that other unrecognized deaths due to accidental poisoning occurred in this community.

The Bright Spot in this Project.—It is estimated that the mortality rate has fallen from approximately 1500 in 1950 to approxi-

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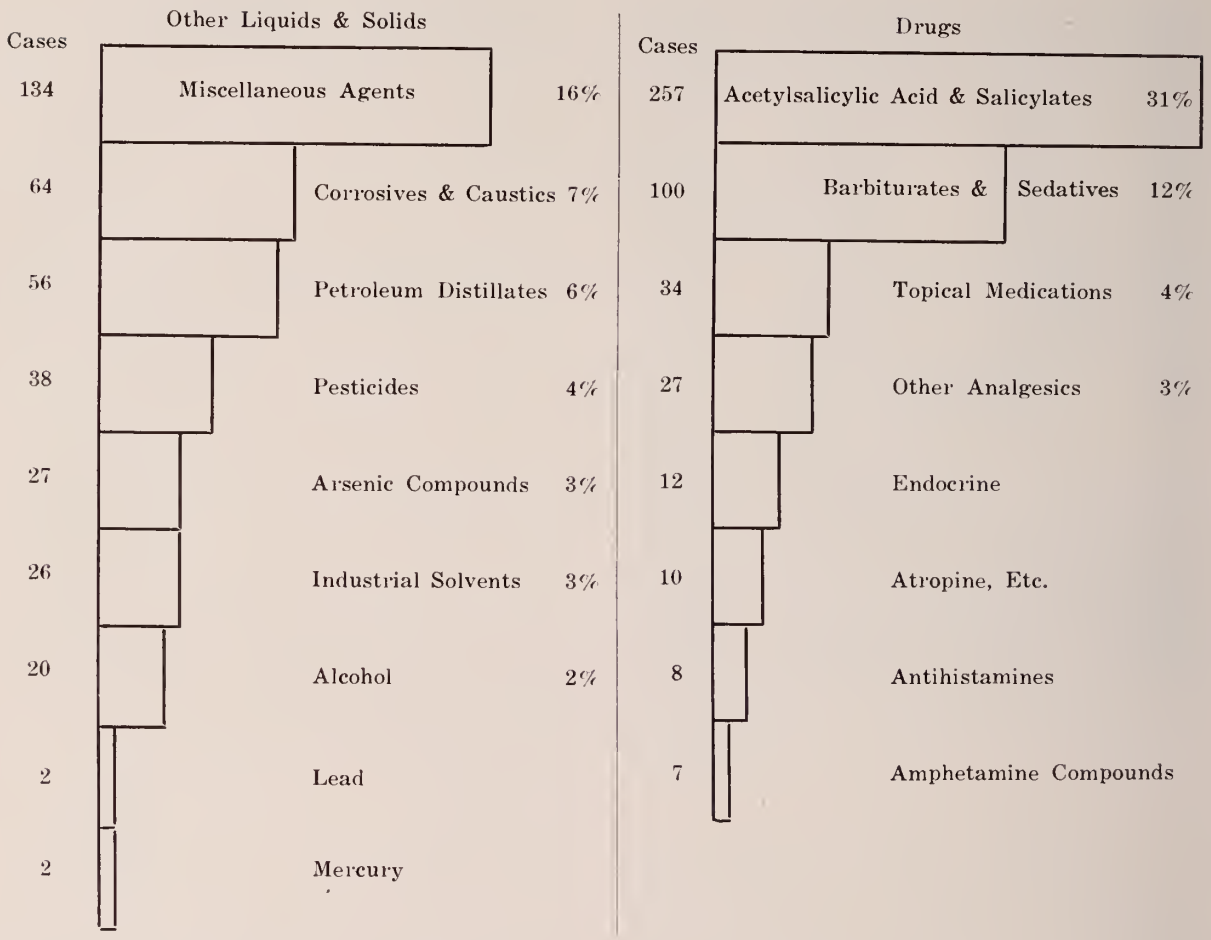
* Chairman, Subcommittee on Accident Prevention of The Medical Society of Milwaukee County.

** Columbia, Milwaukee Childrens, Milwaukee County Emergency, Milwaukee County, Johnston Municipal.

*** Dr. Elaine Thomas and Mr. George A. Dundon.

Incidence of Accidental Poisonings by Agent—Milwaukee County 1956—Total Cases 826



mately 1100 in 1956, undoubtedly as a result of improved treatment facilities, education of the public and manufacturers, and protective legislation. This approach to the problem of accidental poisoning prevention saves lives.

1513 E. Capitol Drive

QUACK FILM AVAILABLE TO MEDICAL SOCIETIES

If you saw Armstrong Circle Theatre's *"The Meanest Crime in the World"*, on TV last March 19, you're probably wondering if this excellent film on cancer quackery is available for medical society showings. It is! Just write Clyde O. Hess, Manager of Public Information, Public Relations Department, Armstrong Cork Co., Lancaster, Pa.

The hour-long kinescope shows how a cancer quack dupes three people until he is tracked down by the Food and Drug Administration. It can't be shown on TV but it should make an interesting program for club meetings. The kines are limited in number so be sure to reserve one well in advance.

Experience With an Antibiotic Combination of Tetracycline and Oleandomycin Used Routinely for Antiinfective Therapy in an Office Practice

By JOHN R. TALBOT, M. D.*
Madison

THIS is a report of clinical experience with Signemycin**, an antibiotic combination of tetracycline (167 mg.) and oleandomycin (83 mg.) in my internal medicine practice.

During the winter of 1956–1957, patients requiring antiinfective therapy were treated with this combination. In each instance the causative agent was identified; and its sensitivity to various antibiotics was determined, thus providing a rational basis for evaluating the efficacy of the treatment.

MATERIALS AND METHODS

Of the 44 patients treated, 23 were male and 21 female, with ages ranging from two to 66 years. Oral therapy with tetracycline-oleandomycin was initiated promptly after a complete physical examination. In each case cultures for bacteriologic study were made at the time of initial examination, and the sensitivity of all pathogens was determined by the disk method to the following antibiotics: penicillin, streptomycin, tetracycline, oxytetracycline, chlortetracycline, erythromycin, chloramphenicol, and oleandomycin. Terminal cultures were also made on occasion.

The dosage of tetracycline–oleandomycin was usually 1 gm. daily for adults, and proportionately less for children, according to weight. Treatment was generally continued for not less than one week, and was not abandoned until all evidence of inflammation had disappeared or it was judged that the therapy was ineffectual and should be changed.

The clinical course was observed periodically on an outpatient basis in all but two patients; these two exceptions were patients who were hospitalized subsequent to the initial office examination because of the severity of their symptoms. One had a Gram-negative genitourinary tract infection that did not respond as well to the combination as it did to tetracycline alone. The other, who had severe asthma, improved on the original medication.

Infection involved the respiratory system in 41 of the patients and the genitourinary tract in two. One patient was treated for a skin infection.

RESULTS

Patients with respiratory system infection were judged free of infection and dismissed from treatment when there was no fever, purulent exudates were no longer seen, regional adenopathy had involuted, all signs of inflammation had disappeared, auscultatory chest findings were no longer present, and terminal cultures, if done, were negative. Skin infection was deemed controlled by antibiotic therapy when there was no longer fever, purulent exudates had cleared, fluctuation had disappeared along with most redness, and regional lymphadenopathy was no longer apparent. In genitourinary infections therapy was regarded as adequate when temperature had returned to normal, the prostate was nontender, and its fluid was free of gross pus and clumping.

The antibiotic combination proved extremely effective in handling all but one of the infections in this series of patients. Generally, these infections were not completely uncomplicated; and it is interesting to note that, when respiratory infections cleared, so also were their complications improved or cured. These complications included asthma, allergic dermatitis, intercostal neuralgia, and synovitis.

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* Assistant Clinical Professor of Medicine, University of Wisconsin.

** The trade name of Chas. Pfizer & Co. for tetracycline-oleandomycin. The Signemycin for this study was generously supplied by Chas. Pfizer & Co., Brooklyn, N. Y.

The organisms cultured were almost invariably staphylococci of demonstrated virulence *in vivo* and *in vitro* or hemolytic streptococci. Generally, the pathogens were reported sensitive to most of the antibiotics except for the frequent report of streptomycin resistance. Of the total number of organisms cultured and tested, four or approximately 10 per cent were resistant to pencillin. Only one, *Escherichia coli*, was resistant to oleandomycin; this particular organism was also resistant to penicillin, streptomycin, and erythromycin, being sensitive to the tetracyclines and chloramphenicol. The patient, in this instance, seemed to get along better with tetracycline alone than when it was combined with oleandomycin. Until the combination was abandoned in favor of tetracycline alone, there was no evidence of lysis of symptoms; but improvement became quickly apparent after the change in therapy was made. It is difficult to explain the seeming antagonism of antibiotics in this case.

The combination of antibiotics was generally well tolerated. Four patients had transient and easily controlled diarrhea. In one a mild vaginitis developed, but it cleared without special treatment in a few days following cessation of therapy; and one had pruritis ani. Another patient complained of drowsiness, but this was probably caused by a concomitantly administered antihistamine.

DISCUSSION

There has been increasing apprehension for several years that the day might come when resistant strains of staphylococci would create an insurmountable problem in this antibiotic era of medical history. Infections due to *Micrococcus pyogenes* var. *aureus* that have defied all efforts at control have been reported with increased frequency. From these ever-growing fears have come certain recommendations, such as "saving" some effective drug against these types of infection (by not releasing it for use by the medical profession). It has been wisely counselled that minor infections not be treated by antibiotics, so as not to interfere with immunity-acquiring mechanisms.

Since 1942, when Rammelkamp and Maxon[1] suggested that the cause of therapeutic failure with penicillin in staphylococci infections was due to the emergence of resistant mutants, there has been a persistent effort to stay ahead of this problem by elaborating new approaches. Ungar,[2] in 1943, first pointed out a synergistic action between sulfapyridine and penicillin. In 1947, Klein and Kimmelman[3] demonstrated synergistic activity between penicillin and streptomycin. The development of new antibiotics and combinations of them has naturally followed. Tetracycline–oleandomycin, a physical mixture consisting of 167 mg. tetracycline and 83 mg. oleandomycin, is one of these.

Sobin *et al.*[4] first reported the chemical and antimicrobial characteristics of oleandomycin, finding it particularly effective against Gram-positive bacteria, Mycobacteria, Rickettsiae, large viruses, and certain Protozoa. It is not active against Gram-negative bacteria except *Brucella, Hemophilus*, and *Neisseria*. It does not show cross-resistance with bacitracin, chloramphenicol, penicillin, polymyxin, streptomycin, or tetracycline.

The work of English *et al.*[5] has demonstrated synergistic activity in a combination of oleandomycin and tetracycline. They found not only increased activity against selected strains of *M. pyogenes* var. *aureus*, but also a marked ability of this mixture of antibiotics to retard the emergence of resistant strains.

SUMMARY

The following experience was obtained in routine reliance on one preparation for any antiinfective therapy in an office practice—the preparation being an antibiotic combination, tetracycline and oleandomycin, containing 167 mg. tetracycline and 83 mg. oleandomycin:

1. In 44 patients with bacteriologically diagnosed infection treated with this combination, all infective processes were controlled with the exception of a Gram-negative infection in one patient.

2. The few side effects observed were mild and easily controlled; in no case were they serious enough to warrant changing the antibiotic therapy.

2137 University Avenue.

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Recent Developments in the Sterilization of Arterial Homografts*

By JOHN T. PHELAN, M. D., WILLIAM P. YOUNG, M. D., and ERWIN R. SCHMIDT, M. D.

Madison

THE clinical application of arterial homografts in the treatment of aneurysms, segmental occlusions, and traumatic conditions of the arterial tree is now a generally accepted surgical procedure. At the present time, the demand for arterial homografts exceeds the supply in most communities. In addition, the procurement of these grafts has required an aseptic technique, which has been found to be a tedious and impractical procedure for most institutions. It became apparent that if arterial homografts could be obtained by the pathologist during a routine post-mortem examination without regard to asepsis, the availability of vascular grafts would be greatly facilitated. As a result a number of investigators have turned their attention to methods which would sterilize artery grafts and still secure a graft that was (1) non-toxic to the host, and (2) structurally unaltered by the sterilizing process. It is thus the purpose of this paper to review and comment on recent techniques employed in sterilizing arterial homografts that have been removed in a non-aseptic fashion.

METHODS

Radiation: High intensity electrons have been shown by a number of investigators to be effective in sterilizing a variety of biologic tissue.[1,2] Meeker and Gross,[1] utilizing a high voltage cathode ray, were the first to report the sterilization of aortic tissue by this method. This procedure has been used by Linton,[3] who considers it to be a most satisfactory method for sterilizing artery homografts. Recently Hui and his co-workers,[4] using high intensity electrons, found that heavily bacterial contaminated aortic grafts required levels of irradiation up to 3.2 million "rep"** before they were rendered bacteria free. However, they observed that when aortic grafts were treated with only one-half this amount and implanted in experimental animals, degenerative changes occurred, characterized by subintimal calcification, degeneration of the smooth muscle layer, and fragmentation of the elastic fibers. In some instances these changes were manifest within two months of the implantation of the graft.

McCris, *et al.*[5] investigated the bactericidal effect of gamma radiation from Cobalt60. They found that a radiation dose of two million "rep"** was effective in sterilizing the aortic grafts used in their experiments. In addition, they implanted the irradiated artery segments in the thoracic aorta of dogs and observed these animals for as long as ten months. Grossly, they were unable to detect any evidence of sclerosis or degenerative changes in the implanted grafts. Microscopically, there was thinning of the graft wall; however, no change in the elastic tissue structure or foreign body reaction was noted. Unfortunately, their period of observation was of short duration and the amount of irradiation used was below the minimal requirements to insure complete bacterial sterilization, as stipulated by Hui.[4] At present, the conflicting reports in respect to the different methods of sterilizing aortic tissue by radiation are difficult to evaluate.

Chemicals: A number of chemicals have been used in sterilizing biological tissues; ethylene oxide, ethylene carbonate, ethylene amine, trimethyl phosphate, beta–propiolactone, and absolute ethanol are but to mention a few.[6] At present ethylene oxide and beta-propiolactone have been extensively investigated as sterilizing agents for artery homografts.[7,8] Information regarding the other agents is limited; however, they are mentioned as only a matter of interest.

Ethylene Oxide: Hufnagel[8] was the first to employ this agent to sterilize contaminated

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** "rep", a unit of radiation measure, the Roentgen Equivalent Physical, which is the amount of energy absorbed within a gram of irradiated tissue.

aortic homografts. Since then a number of investigators[7] have verified its effectiveness in rendering contaminated vascular tissue free of micro-organisms. In addition, it has been demonstrated that the arterial homografts sterilized by ethylene oxide retain an essentially normal histologic pattern to their wall, and the elastic and tensile strength patterns are not appreciably altered from the normal. Clinical trials using ethylene oxide-treated grafts have been reported by Hufnagel and others[7,8] with good results.

Unfortunately, ethylene oxide is a highly volatile and explosive chemical and requires special laboratory precautions in its use. In addition, prolonged overtreatment of experimental artery homografts with ethylene oxide has resulted in aneurysmal dilatation of the implanted segment.[9]

Beta–propiolactone: Beta–propiolactone is an organic chemical of an ester of hydroxypropionic acid. Hartman and LoGrippo[10] used this agent initially to inactivate viral contaminated plasma and blood. Later these same investigators and their associates[11,12] found beta–propiolactone to be effective in sterilizing artery homografts that were contaminated by a wide range of micro-organisms, which included bacteria and fungi. They also showed that the tensile strength and elasticity properties of the treated grafts were essentially similar to normal control grafts. In addition, from their extensive animal studies the implanted artery homografts sterilized with beta–propiolactone developed changes not unlike grafts that had been removed under aseptic technique and stored in nutrient media. Their subsequent clinical application has established the efficacy of this method; and, as far as can be ascertained, their clinical results have been satisfactory.

In addition to being a superior sterilizing agent, beta–propiolactone is an easily handled laboratory agent. Since it is quite unstable in aqueous solutions, special care is necessary to insure its efficiency by maintaining proper pH levels and temperature controls. To a trained laboratory technician, such measures are considered routine.

SUMMARY

A brief resume of some of the more recent developments in the procurement and sterilization of arterial homografts has been described. At present ethylene oxide and beta–propiolactone appear to be the most practical methods in rendering artery homografts free of contaminants and still preserving the integrity of the graft. It becomes quite apparent that, by applying these agents to artery homografts for sterilizing purposes, the vessels for grafting purposes do not need to be procured under aseptic conditions, and that a once cumbersome method of obtaining a sufficient supply of these materials becomes a somewhat more simplified procedure.

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An Unusual Mesenteric Cyst

By LAIRD McNEEL, M. D.
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ON THE night of August 29, 1957, a 38-year-old nurse was riding home from caring for a friend who had been critically injured in an automobile accident. She loosened her seat belt, informed her husband that she was going to catch up on sleep with a short cat-nap, and slouched down in the seat. A few moments later their car was involved in a head-on collision. She was jack-knifed over the seat belt and whipped into the dashboard. She sustained the following injuries:

1. Head injury against dashboard, with paresis of third, sixth and seventh cranial nerves on left; fracture of left zygoma.
2. Fracture of shaft of left ulna.
3. Fracture of second lumbar vertebra.
4. Abdominal injuries of undetermined extent.

The latter injuries gave us the most trouble, and it is with them that we are concerned here. The patient did very well following the accident, but the abdominal injuries gave her much discomfort. There were a few small skin abrasions and an ecchymotic band just under the umbilicus and across the abdomen, delineating the area where she had been propelled against the seat belt. Microscopic hematuria developed and, although there was no peripheral extremity paralysis, she was unable to void and an indwelling catheter was instilled. A marked ileus developed and persisted for about three weeks. During this time gastric suction and enemata were required. The ileus gradually cleared, and on September 22 the patient began to enjoy nourishment orally. On September 23 she complained of fullness, bloating and early satiety. These symptoms progressed rapidly, and within a few days she was unwilling to eat and complained of pain in the left side. Some time after the development of symptoms, a small tender mass was discovered in the left upper quadrant. The mass was tender with limited movability within the quadrant, did not change position with respiration, and seemed to sustain a slow increase in size, proportional to the increment in the patient's symptomatology.

RADIOLOGIST'S REPORT

On September 2, the patient's fifth hospital day, an abdominal flat plate was taken to determine the extent and, if possible, the origin of the ileus present at that time. The radiologist's report is as follows:

September 2, 1957—Abdomen

A portable film of the abdomen shows an opaque tube to be present with the tip in the stomach. Segments of small bowel are moderately dilated by gas. There also appears to be some gas in the colon.

Impression: Probable adynamic ileus. The film does not suggest mechanical obstruction.

On September 24 another flat plate was taken which showed an air-containing cyst in the left upper quadrant. Barium swallows demonstrated that the bowel continuity was intact. Both films were exposed in bed, using the portable unit, and the radiologist's report at that time is given in detail because of its importance in arriving at a diagnosis.

September 24, 1957—Abdomen

There is scattered gas and fecal material in the colon. There are few isolated minimally gas-distended segments of small bowel. There is a small amount of gas in the stomach. There is an 8 x 11 cm. radiolucent area just to the left of the mid abdomen. The margins of this radiolucent area are smooth. No mass shadows are seen.

Impression: Possible cystic intraabdominal structure containing gas to be considered. The intestinal gas pattern is not suggestive of mechanical ileus. It is possible that the cyst-like structure could be connected with some portion of the intestinal tract.

Recommendations: A small amount of barium by mouth with films taken at appropriate intervals to follow the course of the contrast media through the intestinal tract. A lateral film of the abdomen is also indicated.

Small Bowel Series (with patient in bed and using portable apparatus): The cystic structure containing gas is located just posterior to the anterior abdominal wall. Films taken at intervals up to the three-hour interval failed to show any connection between this structure and the intestinal tract. At the three-hour interval the contrast media is in the proximal large bowel. The intestinal mucosal pattern appears normal throughout. There is nothing to indicate any obstruction of the intestinal tract.

Impression: No evidence of connection between intestinal tract and air-containing cystic structure located in anterior portion of abdomen.

September 25, 1957—24-Hour Film of Abdomen (using portable apparatus):

The film of the abdomen taken 24 hours after administration of barium meal shows that the contrast media is scattered in normal-appearing large bowel. The previously described air-containing cyst is again seen to the left of the mid abdomen. There is no evidence of contrast media within this cystic lesion.

Impression: Air-containing cyst within abdomen with no evidence of connection with the gastrointestinal tract.

TREATMENT

It is reasonable to assume that the cyst developed sometime between the film exposures on September 2 and September 24. A diagnosis of probable mesenteric cyst was made, and on October 2 an exploratory laparotomy was performed. Through a left paramedian incision, the abdomen was opened and a grapefruit-sized cyst was discovered lying between the leaves of the transverse mesocolon. The cyst contained a nonodiferous gas and about one and one-half cubic centimeters of yellowish fluid resembling necrotic fat. About six or eight loops of small bowel were attached by fresh adhesions to the undersurface of the cyst wall, and these were easily freed. As it was impossible to free the cyst by dissection, it was decided to resect a portion of the transverse colon, wedge the mesocolon, and restore continuity with an end-to-end anastomosis. This was done, and the patient returned to her room in good condition. Her recovery was uneventful except that she sustained, after the eighth postoperative day, a great deal of abdominal discomfort and cramping; and although she expelled flatus from the fourth postoperative day on, it was not until the twelfth postoperative day that she passed her first unaided bowel movement since the day of the accident.

PATHOLOGIST'S REPORT

Gross Description: One piece of tissue is a mass of partially hemorrhagic fatty omentum 7.0 cm. in diameter. The other part of the specimen is a segment of colon 13.0 cm. in length. No abnormalities are seen in the mucosal surface. However, along its mesenteric border, nestled in the concavity of the specimen, is a partly broken cyst wall. The total diameter of the lesion measures about 5.0 cm. The external surface appears to be composed of the mesentery and is hemorrhagic but smooth. The lining is similar. There is no communication with the lumen of the bowel.

Histology: The mucous membrane of the colon has a normal gland pattern with active secretion and uniform cell structure. Submucosa and muscularis are likewise not remarkable. The cystic structure adherent to the colon involves its mesenteric side and is composed of a heavy, edematous, fibrous wall varying in thickness and consisting predominantly of proliferating fibroblasts infiltrated by patches of hemorrhage and exudative cells, among which plasma cells and lymphocytes predominate. The lining consists of a zone of granulation tissue in which there are many histiocytes and multinucleated foreign body type giant cells, the surface being covered by a thin layer of fibrin and cellular debris. No foreign material is identified in the tissue. The thinner portions of the cyst wall have a similar construction.

Diagnosis: Cystic hematoma of mesentery of colon.

DISCUSSION

Mesenteric cysts are among the rarest of adbominal tumors. Since their first description in the fifteenth century by Antonio Benevieni to the present time, there have been some 600 cases reported.[1] Because of their scarcity, they are poorly understood, and none of the theories advanced to account for them explains the origin of the many different varieties. There is general agreement that the true mesenteric cyst is a thin-walled structure containing no mucosa and

lined by fibroblastic elements containing no muscle fibers. It is filled with chylous or serous fluid. We have been unable to find any reported case in which gas alone was the content. Mesenteric cysts can occur at any age, being reported at three days[2] and at 72 years,[3] and are apparently more common in women. Reviews of the literature seem to indicate more common occurrence in the small intestine, especially in the region of the ileocecal valve. The origin of these cysts is obscure, but most theories assume derivation from lymphatic structures either as a congenital anomaly or traumatic artifact. Lee[4] presents experimental evidence to substantiate the latter hypothesis. However, we were unable to discover any reported cases which appeared to have developed as a direct result of a blow or traumata such as apparently occurred with our patient.

Lee[4] postulates the cyst is formed by rupture of a lymphatic vessel, and further extravasation between the leaves of the mesentery with subsequent formation of an inflammatory or reactionary cyst wall. If this theory is correct, there is no explanation for the lack of fluid and presence of gas in the cyst in our patient's abdomen. The same applies as refutation to the supposition that it might have been caused by an extravasation of blood. On the other hand, the cyst was like a true mesenteric cyst in that it did not communicate with the bowel and the gas it contained did not have a fecal odor. There was also no evidence of perforation of the abdominal wall or implantation of a foreign body around which such a cyst might have formed as in the case reported by Thorek,[5] in which the cyst wall developed around a sponge.

In the case of our particular cyst, it is possible that the gas may have penetrated the bowel wall when it was distended during the long period when paralytic ileus was present. During surgery the cyst partially collapsed when pressure was inadvertently applied over the wall. The point of expulsion of the gaseous contents was low on the undersurface near the mesenteric origin, where a small necrotic area was present. It was at this point that the adherent loops of small bowel had been released. Could the application of force at the time of the accident have been such that the mesentery was injured; the leaves partially separated; and then, following the fastening of the loops of small bowel to the point of injury and their subsequent distention, escaping gas to pocket and further separate the mesenteric leaves? Could a fibrotic cyst wall then form around this nucleus? Because of the timing of our x-ray exposures, we can place the formation of the cyst somewhere between the fourth and twenty-second day following the accident. The cyst's gaseous contents and its development during the protracted period of adynamic ileus and bowel distention would favor an explanation of this type.

The diagnosis of mesenteric cysts is usually made on the basis of a movable abdominal mass, though its position in the mesentery can only be postulated. The symptoms are usually pain, nausea, fullness, and sensation of a mass. Intestinal obstruction and peritonitis have been reported.

Treatment is surgical; removal by dissection is the procedure of choice. If this is not feasible, and it usually is not, resection with removal of attached bowel and anastomosis is the second choice. Marsupialization has been successfully resorted to in many cases, though Beahrs *et al.*[6] reported development of a malignancy in a cyst two years following such a procedure.

SUMMARY

A case of mesentery cyst forming apparently from direct trauma is presented. Its development and that of mesenteric cysts in general is discussed. The general features of these tumors are briefly considered.

Burlington Clinic.

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Clinicopathologic Conference

Sponsored by the Section on Pathology, State Medical Society of Wisconsin
Guest Editor: William J. Blake, M. D.

CASE PRESENTATION *

The patient, a 40-year-old, white female, six weeks postpartum, was admitted to St. Luke's Hospital for the first time on December 15, 1957, complaining of epigastric pain. She stated she had had epigastric pain off and on for the past one and a half years. The pains came on at any time of day but usually in the morning. The pains were relieved by baking soda. She only had slight relief from gelusil. During the week before admission epigastric pains had been more severe, frequent, accompanied by nausea, and penetrating to the back. She denied any history of relation of the pain to greasy foods. She had frequent belching but denied melena. Her family history was negative for tuberculosis or cancer. Her living mother had hypertension. The patient denied smoking or drinking. The past medical history was entirely negative except for the history of eight pregnancies, seven of which had gone to completion with normal children. The last delivery was on October 24, 1957. Additional history revealed that the patient had a dry and an occasional productive cough during the week prior to the admission. There was no fever, chills, or chest pains.

PHYSICAL EXAMINATION

On admission temperature, pulse, and respiratory rate were normal. The blood pressure was 104/70. The patient was well-developed, well-nourished, cooperative, but pale. The only positive physical findings were a few crepitant rales at the left lung base and a very slight tenderness in the epigastrium. A clinical diagnosis of peptic ulcer and possible gallbladder disease or chronic pancreatitis and acute bronchitis with pneumonitis was made and diagnostic studies were begun. Fifty milligrams of meperidine hydrochloride (Winthrop, Breon) was ordered for pain. The pelvic examination was negative. Chest and complete gastrointestinal series showed no organic pathology in the upper or lower gastrointestinal tract. There was widely distributed coarse linear infiltration throughout both lungs (fig. 1). The exact etiology could not be determined by the roentgen appearance. The picture was suggestive of chronic inflammatory disease, including sarcoidosis, collagen disease or resolving acute pneumonitis. Gallbladder series showed a normal gallbladder.

During her hospitalization, the patient was noted to have a marked nonproductive cough and she complained of epigastric pain. She was discharged for the holidays on December 24, 1957, with a few rales remaining in both lung fields.

Fig. 1—Chest x-ray December 16, 1957 showing coarse linear infiltration rather widely distributed through both lungs.

* From St. Luke's Hospital, Milwaukee.

SECOND ADMISSION

She was readmitted at midnight on December 31, 1957, by ambulance. While at home, she was apparently well, except for occasional dry cough and choking spells. She had had no chills, fever or coryza. Three days before the second admission, she began having frequent productive cough with a large amount of mucus and froth. This was accompanied by lower chest pain which progressed to dyspnea. Physical examination was essentially the same as on the first admission except that the respiratory rate was 26 per minute and the patient was dyspneic. Also, there was some dullness at the right lung base. Chest x-ray (fig. 2) showed a marked increase in the infiltration seen on the previous examination. At this time, x-rays suggested the possibility of sarcoidosis, collagen disease, pulmonary adenomatosis or fungus infection. The electrocardiogram showed T-wave changes compatible with myocardial ischemia of undetermined etiology. Sputum studies revealed a budding yeast as the predominant organism, which, on culture, proved to be nonpathogenic Monilia species. X-rays of the chest showed a rapid progression of the pulmonary densities described above; and on January 4, 1958, there were rather large patches of granular nodularity seen. Skin tests for coccidioidomycosis, blastomycosis, and histoplasmosis were negative. Sputum examination for tuberculosis was negative in the concentrated smear. She improved slightly for several days but dyspnea continued even with oxygen. On January 9, 1958, the rectal temperature rose to 103 degrees. This was the first temperature elevation since the onset of the present illness. The blood pressure became unobtainable. The skin became pale. She perspired and became cold and clammy. She expired after being in a state of shock for five hours.

Fig. 2—Chest x-ray December 31, 1957. Increased pulmonary infiltration with more nodular and patchy configuration.

TABLE 1—LABORATORY REPORTS

	December 16	December 21	December 31
Blood Hemoglobin	11.0		13.2
Hemotocrit	32		38
White Blood Cells	7,150		8,300
Stabs	4		2
Segmented Neutrophiles	62		61
Lymphocytes	34		35
Monocytes			
Eosinophiles			
Basophiles			1
Sedimentation Rate	35		Serum Aschheim-Zondek Test, negative
VDRL	Negative		
Urine Specific Gravity	1.022		1.023
Color	straw		straw
Reaction	6.0		5.5
Protein	0		0
Sugar	0		0
Sediment	rare RBC		Occasional epithelial cell from vagina
Serum Amylase	64 units		Total protein 5.5 gm.
Prothrombin Time	79%		Albumin 2.4
Bilirubin, direct	.08		Globulin 3.1
total	.24		
Thymol Turbidity	2.5 units		
Zinc Turbidity	10.5 units		
Bromosulphonphthalein	1% retention		
Sputum culture	E. Coli Non-Hem. staph.	Neisseria sp. Non-Hem. staph.	Monilia sp. Alpha hem. strep. Non-Hem. staph.

DISCUSSION

Dr. Maurice Hardgrove: The essential story is that of a 40-year-old female who had epigastric pain for over a year and who had recently been delivered of her eighth child, and in whom a diffuse infiltrating lung lesion developed which caused increasing dyspnea. She died during a febrile shock period.

The epigastric pain could be explained on the basis of an atypical duodenal ulcer, gas-

tric ulcer, gastric malignancy, pancreatitis, pancreatic malignancy, or retroperitoneal sarcoma.

The epigastric pain was relieved by baking soda and to some extent by gelusil. Eventually the pain was accompanied by nausea. This pain was referred to the back and a narcotic was required for its relief.

Abnormal gallbladder, stomach, or duodenal changes were not noted by roentgenography. No roentgen evidence was noted of duodenal deformity due to changes in the head of the pancreas. The amylase was normal when taken during an acute period of discomfort. No displacement of the abdominal contents was noted on the normal colon roentgenogram to suggest a retroperitoneal tumor of a large size. The greater curvature of the stomach was not seen as a smooth outline and upper stomach and esophageal areas were not visualized. The renal borders appeared normal as seen on the colon plate.

Metastatic infiltration in the lungs could occur from the stomach and pancreas, as well as from other organs and areas.

The patient had delivered her eighth child without apparent complications. One might consider the possibility of the lung lesion representing a choriocarcinoma metastasis. The pelvic examination was normal and the Aschheim–Zondek test was negative. There was no indication of a hydatid mole. Ovarian malignancy might also be considered to produce metastatic lung lesions but the ovaries were not found to be enlarged or tender. Leiomyosarcoma would seem unlikely in the presence of a normal-sized uterus.

A spread of an infectious process in the lungs could produce diffuse lung findings. The sputum did not contain acid-fast organism, nor did it contain definitive pathogenic organisms. The Monilia found was considered to be nonpathogenic. A slowly progressive viral pneumonitis seems unlikely. This was not the usual picture of a bacterial mycotic or allergic disorder.

There was lower anterior chest pain to suggest the possibilities of pericarditis, coronary insufficiency, and myocardial infarction. However, the story, the physical findings, and the electrocardiograms were not diagnostic of such affairs.

The physical and roentgenographic findings do not permit one to define the lung findings as due to a primary neoplastic process. No history of cigarette smoking is given. No peripherally palpable lymph glands were found. The superior mediastinum might have been enlarged but a distinct tumor outline was not seen. The lung infiltration was described as linear and diffuse, developing eventually to a granular nodularity. No eosinophilia, neuritis, or renal involvement were apparent to suggest an arteritis. This seems to be an unusual and rapid outcome for sarcoidosis. Large, isolated, well-defined metastatic nodules such as are seen in choriocarcinoma, breast cancer, or renal neoplasm were not described. Acute beryllium poisoning seems unlikely.

Dr. O. A. Sander: Was there any exposure to the acid compounds of beryllium in this case?

Dr. W. J. Blake: No.

Dr. O. A. Sander: There have been cases of acute beryllium poisoning described with lung changes which look exactly like this, and which are due to an acute pulmonary edema.

Dr. H. H. Wright: The initial x-ray examination was on December 16. On oral cholecystography, the gallbladder showed good function with no evidence of gallstones. No evidence of organic pathology was seen in the upper gastrointestinal tract on barium meal examination. The chest x-rays showed coarse linear infiltration rather widely distributed through both lungs. Exact etiology was undetermined, but the appearance was considered most likely due to chronic inflammatory disease. The possibility of sarcoidosis was suggested, although there was no distinct evidence of mediastinal or hilar adenopathy. Pulmonary infiltration associated with some form of collagen disease was considered. An acute diffuse pneumonitis was considered a less likely possibility. Chest examination on December 19 showed no definite change. Barium enema examination of the colon on December 20 showed no abnormality in the colon.

Chest reexamination on December 31, 1957, showed some increase in the pulmonary infiltration with some areas showing a more nodular or patchy configuration. In addition to previously considered etiologic factors, pulmonary adenomatosis and tuberculosis were also considered. The final chest examination on January 4, 1958, showed further increase in the pulmonary infiltration with more evi-

dence of nodular and confluent patchy densities in the lungs. No pleural effusion was demonstrable. No abnormality was seen in the bony structures.

Doctor Hardgrove: The patient was afebrile until the terminal stage was reached and no evidence of sepsis was present. No petechiae, leukocytosis or cardiac murmurs appeared.

No evidence of primary breast, thyroid, renal, adrenal, skin, bone, gallbladder, or colon neoplastic lesions was established in this patient. Hidden growths, hard to find, are not uncommon in the stomach, pancreas and colon. There was no distint clinical or laboratory evidence to incriminate the liver.

In many women the size of leg varicosities is increased in the process of bearing children, but apparently it did not happen in this case. The chest roentgenogram did not show large areas resembling peripheral lung infarctions. She did not have well-defined pleuritic pain or hemoptysis. In spite of progressive and diffuse linear infiltrations of the lungs, the pulmonary second sound was not increased. No true evidence of right heart strain was found, though it might have been suspected.

The high globulin content of the blood serum was not diagnostic, for this is found in inflammatory, connective tissue and neoplastic disorders. There was nothing in the picture to suggest multiple myeloma. A mild anemia was present.

The final picture of fever and shock was of interest. There was nothing to suggest that the heart was involved in a primary process which could have so weakened it that it would have been unable to propel blood. Pericardial tamponade due to blood or fluid to prevent the heart from filling seemed unlikely. There was no record of blood loss, though a gastrointestinal lesion might suddenly bleed. The chest roentgenograms suggest infiltrative pulmonary changes which could have hindered the blood flow through the lung. Lungs involved by metastatic infiltrations are poorly equipped to handle thrombi or emboli. There were no skin changes to suggest an Addisonian crisis. Shock due to anoxia and cellular degeneration and involving all cells in a severely ill patient is one for which we have no adequate repair. This type of dissolution may have been the cause of shock in this patient.

The persistence of epigastric and back pain associated with increasing pulmonary symptoms and signs was impressive and strongly suggested an intraabdominal neoplasm with extension to the lungs. The pulmonary lesion appeared to be an infiltrative metastatic process.

The source of this chest lesion may well have been a hidden cancer of the stomach.

A second possibility would have been a neoplasm of the pancreas.

Dr. J. E. Morgan: I have seen two cases similar to this one. One was due to a carcinoma of the gallbladder and the other to a primary carcinoma of the liver.

AUTOPSY FINDINGS

Dr. W. J. Blake: This case is presented primarily from two points of view. First, there is the lung problem. This presents a most interesting differential diagnosis of lung disease and all the things that were mentioned, including some others such as pulmonary amniotic fluid emboli and extensive pulmonary adenomatosis and Friedländer's pneumonia, were considered clinically.

At post mortem, the lungs were both totally consolidated, firm, and on section exuded a sticky mucoid fluid, resembling an organizing Friedländer's pneumonitis or possibly adenomatosis. The pleural surface of the lungs showed the lymphatics accentuated as rigid white cords. There were no localized large tumor masses. We still did not know the real nature of the lung pathology until we opened up the stomach near the end of the autopsy. And here, not on the greater curvature, but on the anterior wall in the antrum was a large fungating ulcerated carcinoma, with a large ulcer in the center.

The microscopic picture shows that the tracery of the pleural lymphatics we saw in the gross is actually metastatic tumor in what is known as "lymphangitic spread" permeating all the lymphatics in the subpleural area. Another microphotograph shows the lymphatics around a bronchiole, filled with tumor tissue. A third shows the mucus production by the tumor cells. Some of these cells around the edge showed the characteristic blue staining of mucus. I'd like to suppose that a lot of the mucus in her sputum was actually produced by the tumor cells. It might be tempting to propose a syndrome of excessively mucoid sputum, dyspnea, and

VETERANS ADMINISTRATION HOSPITAL

WOOD, WISCONSIN

ELEVENTH ANNUAL CLINICAL DAY

Marquette University Medical School Dean's Committee

Saturday, June 21, 1958

8:30 A.M.

WELCOME ADDRESS: Mr. D. C. Firmin, Manager, VAC, Wood, Wisconsin.

INTRODUCTORY REMARKS: C. P. Henke, M.D., Director, Professional Services, VAC, Wood, Wisconsin; E. A. Bachhuber, M.D., Associate Dean, Associate Professor of Surgery, Assistant Director of the Department of Surgery, Associate in Anatomy, Marquette University School of Medicine.

8:45 A.M.

MODERATOR: Joseph P. Looze, M.D.

Duodenal Ulcer: Surgical Implications, Complications, and Mortality. Jack J. Frederick, M.D., Surgery.

Hepatic Manifestations of Sarcoidosis. Reuben Beezy, M.D., Medicine.

Laryngograms and Other Diagnostic Aids by Use of Contrast Media. Harry D. McGee, M.D., Otorhinolaryngolgy, and George J. Owens, M.D., Radiology.

Hypercalcemia Associated with Grave's Disease. Richard O. Sternlieb, Medicine.

Comparison of Clinical Results with Bone Bank and Autogenous Bone Grafts. Jack D. Spankus, M.D., Orthopedics.

The Role of Exercise in Postural Low Back Pain. Albert Cohen, M.D., Physical Medicine.

The Use of the Artificial Kidney in Tophaceous Gout with Nephropathy. William R. Taylor, M.D., Medicine.

INTERMISSION: 10:30 A.M. to 11:00 A.M.

MODERATOR: Raymond R. Watson, M.D.

Clinical and Histologic Effects of Intradermal Cortico-Steroid. Louis Simonson, M.D., Dermatology.

Clinical Experiences With a Plastic Approach to Urethral Stricture. Randle E. Pollard, M.D., Urology.

Evaluation of Bentonite and Latex Tests for Rheumatoid Disease. Joaquin F. Lopez, M.D., Pathology.

Ten Year Review of Adenocarcinoma of the Rectum and Sigmoid Colon. Robert E. Bormes, M.D., Surgery.

The Natural History of Mycosis Fungoides. Donald E. Johnson, M.D., Dermatology.

Misconceptions and Dangers with Pentothal. William E. Mateicka, M.D., Anesthesiology.

Each Presentation—Ten Minutes

lack of fever caused by metastatic mucus producing tumors in the lung.

Inside the uterus, there was no chorioepithelioma, but there was some friable material. The chorionic villi and decidual tissue, very hyalinized, still remained four months after delivery. In the ovary there was something that was quite unexpected—a 5 cm. cyst which was not evident on pelvic examination. It contained a tumor nodule which is a granulosa cell tumor. All granulosa cell tumors are not necessarily malignant. They may act benign for many years. There was no evidence of this tumor having spread.

Thus, we have a stomach carcinoma masquerading as primary lung disease. Instead of metastasizing as focal nodular masses, it spread to the lungs by permeation of lymphatics, giving a nonspecific x-ray appearance.

This brings up the second point for emphasis in this case; which is, that gastric carcinoma is often very difficut to diagnose by any means, and this case particularly brings out the difficulty in diagnosing gastric carcinoma by x-ray. The point has been made so often that people have gone to the extreme of doing Papanicolau studies on gastric fluid, which is a very poor medium for cytology studies because of its digestive enzymes which quickly distort the cells. In looking over statistics on gastric cytology smears, I found that according to Papanicolau's own figures he was only able to get 32% positive results in 168 cases of known carcinoma. Using an abrasive balloon, a well-known university group recorded results which were less conclusive because they tested 45 patients with minor gastrointestinal symptoms. Their one cytologically positive case turned out to have a normal stomach, and their 39 cytologically negative cases included a large carcinoma. Because of the mechanical difficulties involved, no specimen could be obtained in 24 additional cases.

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Obstetrical Brief

From the Study Committee of the Maternal Mortality Survey
Division on Maternal and Child Welfare, State Medical Society of Wisconsin

Uterine Rupture After Cesarean Section

With the initial decision to do a Cesarean section, the physician assumes the great responsibility of determining the future pattern of the obstetrical life of his patient. Thus, the type of Cesarean section performed often decides her ultimate fate. When indications exist, the decision to do a Cesarean section should be influenced solely by the welfare of the patient and without consideration of the desire by any hospital to maintain a moreorless arbitrary statistical limit on such procedures. The initial section presents few hazards to the mother except those which reflect the hazards necessitating the section, such as praevia, abruptio, or distotia. This is emphasized by the many hospitals reporting as high as several thousand consecutive sections without maternal mortality. One Wisconsin hospital, for example, reports 2,195 Cesarean sections without maternal mortality.

Repeat Cesarean sections carry with them some increased hazard. These hazards are secondary to intraabdominal complications resulting from the first Cesarean section. These may result in danger to the mother and not infrequently are hazardous to the infant because of the technical difficulty and time necessary for doing the repeat Cesarean section. This is especially true when general anesthetic agents are used. Further hazard to the baby as a result of repeat Cesarean sections is the failure to correctly appraise the duration of gestation with resultant premature infants. It is common knowledge that the premature product of a Cesarean section frequently does poorly.

It is generally accepted that a patient who once has a section should have a repeat section. However, Cosgrove[1] reports that approximately 75 per cent of patients in most categories (*i.e.*, toxemia, abruptio, or praevia) who initially have sections could subsequently deliver vaginally. He also states that approximately 25 per cent of those who initally had sections for cephalic pelvic disproportion could subsequently deliver vaginally. Nevertheless, there is real hazard when conducting labors subsequent to previous Cesarean section. The doctor who would assume this responsibility must conscientiously remain with his patient throughout labor so that should rupture occur, immediate surgical intervention can be instituted. Cosgrove indicates that in a series of births reviewed there were 12 total ruptures of the uterus subsequent to previous Cesarean section; all of these had previous classical sections. Seven incomplete ruptures were also reported. Though all types of Cesarean scars can rupture, the classical scar presents this potential two-to-one in comparison to the low cervical scar. Studies indicate that this accident has occurred all too frequently in our own state with resultant maternal demise. Several cases occurred with the patient in the hospital awaiting elective repeat Cesarean section the following morning.

How can this hazard be combatted? Cesarean sections should be employed only when absolutely indicated and then the low cervical section rather than the classical should be the choice, with some limited exceptions. The patient who is permitted to deliver vaginally, subsequent to a previous Cesarean section, must be attended by her doctor throughout her labor. Any history of infection or faulty wound healing with the initial section should contraindicate any attempt at delivery vaginally. Any previous section patient who is to be either delivered vaginally or to be delivered by repeat Cesarean section should be warned to contact her physician day or night if any unusual symptoms of pain or bleeding occur. Any nurse in charge of preoperative patients should be taught to respect contractions and report them regardless of their apparent insignificance when the patient in labor has previously had a Cesarean section. It is the doctor's responsibility to respect the report of the patient or the nurse and to immediately investigate the status of the patient who is either to be delivered vaginally or by repeat Cesarean section. Any complacency of the physician in

(Continued on page 252)

Polio or Aseptic Meningitis?

As It Looks to Your State Board of Health

AS IMPROVED techniques for viral isolation were developed it became apparent that some of the classical concepts of poliomyelitis must be modified. Tissue culture isolation made it obvious that many cases heretofore diagnosed as "nonparalytic polio" were in fact meningitides due to viral agents other than the poliomyelitis group. Of these agents, the Coxsackie and ECHO groups have recently received much publicity. However, other viral and spirachetal agents such as those of mumps, lymphocytic choriomeningitis, herpes simplex, and leptospirosis have been implicated etiologically in this syndrome. The term "aseptic meningitis" has been adopted as the descriptive term for the whole group.

Aseptic meningitis was introduced into the literature by Wallgren in 1925. His definition of this entity is as follows:

1. Acute onset with obvious signs and symptoms of meningeal involvement.
2. Alteration of cerebrospinal fluid typical of meningitis. The cerebrospinal fluid may show a small or large number of cells.
3. Absence of bacteria in cerebrospinal fluid, as demonstrated by appropriate direct or cultural techniques.
4. Relatively short, benign course of illness.
5. Absence of local parameningeal infection (otitis, sinusitis, trauma, etc.) or a general disease which might present meningitis as a secondary manifestation.
6. Absence from the community of epidemic disease of which meningitis is a feature.

The last of these requirements has been discarded because epidemics of aseptic meningitis have now been demonstrated. From these criteria one can see that this entity may be clinically indistinguishable from nonparalytic polio.

In 1957 preliminary results of viral isolations from stool done from all parts of the state (excluding Milwaukee) revealed 81 Coxsackie and ECHO isolations and two polio isolations. This has led some to suspect that all, or nearly all, nonparalytic polio in the past was due to these agents. This is probably not so. Studies have shown that the proportion of aseptic meningitis due to polio virus varies from year to year and even between different localities in the same year. Thus, much has yet to be determined concerning the natural history and relationship of these viruses.

Clues to the differentiation of aseptic meningitis from nonparalytic polio may be gained from last year's experience in Wisconsin. Some physicians noted that some of their cases first diagnosed as nonparalytic polio had shorter, more benign courses than the usual polio cases. Also, it was noted that the disease seemed more communicable than clinical polio, *i.e.;* more cases in family members and contacts were occurring than usually seen in polio. Occasionally the white blood cell count of the cerebrospinal fluid was higher than would be expected in polio. Particularly in the eastern part of the state a rash with aseptic meningitis was sometimes related to infection with one of the ECHO groups of viruses. Thus the occurrence of a febrile rash either in a patient with nuchal rigidity or in a family member of a supposed case of polio may lead one to suspect nonpolio disease. It should be emphasized that these are not definite distinguishing clinical features, but they may be signs that serve to arouse suspicion. The risk of increasing paralysis by allowing early ambulation should lead one to adopt conservative treatment in all cases of illness suspicious of polio.

The State Laboratory of Hygiene has facilities for virus isolation. However, the growing demand for this work has far exceeded the funds and personnel necessary to fulfill all requests. The valuable procedure of differentiating a viral agent as being polio or not is a relatively simple task. The procedure of more specifically typing an unknown viral agent such as one of the various Coxsackie and ECHO strains is exceedingly time

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Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee
F. E. SHIDEMAN, M. D., University of Wisconsin, Madison

Drugs and the Blood Ammonia Level

Bacterial enzymatic action on urea and other nitrogenous compounds in the gastrointestinal tract makes this site a major source of blood ammonia, a fact which suggested to Fisher and Faloon[1] that antibacterial agents effective against intestinal organisms might be beneficial in hepatic coma. They, therefore, studied the effect of oral neomycin in 11 patients with hepatic cirrhosis. Six had cirrhosis without neurologic disturbances, their blood ammonia values being moderately elevated or high-normal before therapy. When 12 gm. of neomycin were given daily, the ammonia concentration was strikingly reduced within 48 hours in five of the patients. The sixth had a marked decrease at 96 hours. The changes occurred despite the ingestion of up to 120 gm. of protein daily. During this period all blood ammonia concentrations were within the normal range. Within 48 hours of withdrawing neomycin, the blood ammonia rose.

Two patients with clinical evidence of ammonia intoxication were stuporous. They were fed 10 and 90 gm. of protein daily, respectively, by stomach tube. A third patient ingested 50 gm. of protein daily. Regardless of the protein intake, a significant reduction in blood ammonia occurred within 24 hours after beginning neomycin therapy. Mental clearing followed 24 to 48 hours later. Trials with 8 gm. of neomycin daily were as effective as those with 12 gm.

Stool cultures obtained during neomycin administration were sterile or revealed urease-negative organisms. The concentration of neomycin in the blood was insignificant except in the presence of renal disease with nitrogen retention.

These results indicate that oral neomycin significantly reduces blood ammonia levels in patients with cirrhosis regardless of the presence or absence of neurologic changes. This probably is due to decreased ammonia production in the intestine because of an altered bacterial flora. Fisher and Faloon[1] point out that neomycin has several desirable characteristics as an agent for sterilizing the intestinal tract: poor absorption from the intestinal tract, a wide spectrum of activity against both Gram-positive and Gram-negative organisms, and the rare occurrence of resistant organisms. Toxic reactions, which are rare, usually occur only after parenteral administration in the presence of pre-existing renal disease.

So much, then, for an apparently effective agent in combating excessively high blood ammonia levels. The reverse of the coin was presented by Ticktin and associates[2] who reported the apparent association of ammonia intoxication with ammonium chloride administration in a patient with congestive heart failure. Evidence of cerebral dysfunction (such as drowsiness, confusion, lethargy, and even coma) occasionally is associated with severe congestive heart failure, and it has been suggested by earlier observers that the cerebral dysfunction may be due to an associated hepatic insufficiency in some patients.

The patient of Ticktin, *et al.*[2] was a 50-year-old man who was hospitalized because of severe shortness of breath of six weeks duration. Since age 17, he had had hypertension with dyspnea. Physical examination revealed moderate dyspnea, enlarged heart, moist rales at both bases, tender and enlarged liver, shifting dullness, a fluid wave, and pitting edema of the lower extremities. Blood pressure was 280/180; blood urea nitrogen, 20 mg./100 ml. The urine gave a four plus test for albumin. Carbon dioxide-combining power was 63 volumes per cent. Liver function test disclosed 42 per cent retention of bromsulfalein.

The patient was placed on a low salt diet, continued on maintenance digitalis and given a mercurial diuretic. Both reserpine and pentolinium bitartrate (Ansolysen) were prescribed. The next day, ammonium chloride, 2 gm. orally 3 times daily, was started. The patient responded well and the dyspnea and orthopnea decreased. There was regression of the edema and blood pressure fell to 150/100. On the fourth day, the patient became stuporous, confused and occasionally

hyperactive. A gross resting tremor of the upper extremities appeared. Except for hyperactive reflexes, the neurologic examination was noncontributory. Lumbar puncture disclosed only an elevated cerebrospinal fluid pressure of 360 mm. of water. A repeat blood urea nitrogen test was not significantly changed. The next day, the patient became more stuporous and the characteristic odor of fetor hepaticus was noted. The ammonium chloride was discontinued, the patient having received 20 gm. in three days. Liver biopsy showed well-preserved hepatic architecture, with minimal fatty infiltration, small focal areas of necrosis, and only a slight amount of bile retention, particularly around the central vein. Before discontinuance of the ammonium chloride there was elevation of the blood ammonia and a slight increase in glutamic oxalacetic transaminase. The electroencephalogram disclosed diffuse, abnormally slow activity; the rate of cerebral blood flow and oxygen consumption was significantly reduced, and the cerebrovascular resistance elevated. On discontinuance of ammonium chloride, the arterial ammonia fell. The patient, nevertheless, lapsed into profound coma and died on the seventh day. Autopsy permission was not obtained.

Ticktin and his co-authors[2] point out that this patient's coma may have been due to an intracerebral hemorrhage, hypertensive encephalopathy, or hepatic insufficiency. But intracerebral hemorrhage seemed unlikely to them because there were no localizing signs before coma developed. The high mean arterial pressure, and the high cerebrovascular resistance favored hypertensive encephalopathy. However, the probability of hepatic insufficiency as the causative factor was considered to be strongly supported by the development of cerebral dysfunction, fetor hepaticus and flapping tremor and the changes in the electroencephalogram.

I think it must be conceded that, even though the case against ammonium chloride in this instance is not proved, caution in the use of the drug in the presence of cerebral manifestations or severely impaired hepatic function is probably wise. However, ammonium chloride has been with us for a long time and its proper use has been very rarely associated with toxic manifestations except in individuals whose kidneys are unable to protect against acidosis through production of ammonia and excretion of a maximally acid urine. Many of the new and relatively unstudied drugs are being used in an utterly reckless way nowadays, and I would therefore be hesitant to foster too great disquiet regarding an old standby like ammonium chloride with an over-all record of pretty fair reliability.—HARRY BECKMAN, M. D.

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(Continued from page 249)

prompt response and investigation, once notified, becomes his responsibility. This complacency could result in another maternal mortality statistic.—F. J. HOFMEISTER, M.D.

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(Continued from page 250)

consuming. Therefore, it is practical only to do such typing on a study basis where an epidemic of disease occurs and an integrated, epidemiological, clinical and laboratory study is being carried out.

The State Board of Health is interested in learning of communities having an increased incidence of aseptic meningitis thought to be due to nonpolio agents. It is through study of these communities that much useful information can be gained concerning the clinical features and epidemiology of these diesases. —KENNETH R. WILCOX, M.D., *Officer in Epidemiology Intelligence Service, Communicable Disease Center, U. S. Public Health Service, assigned to Wisconsin State Board of Health.*

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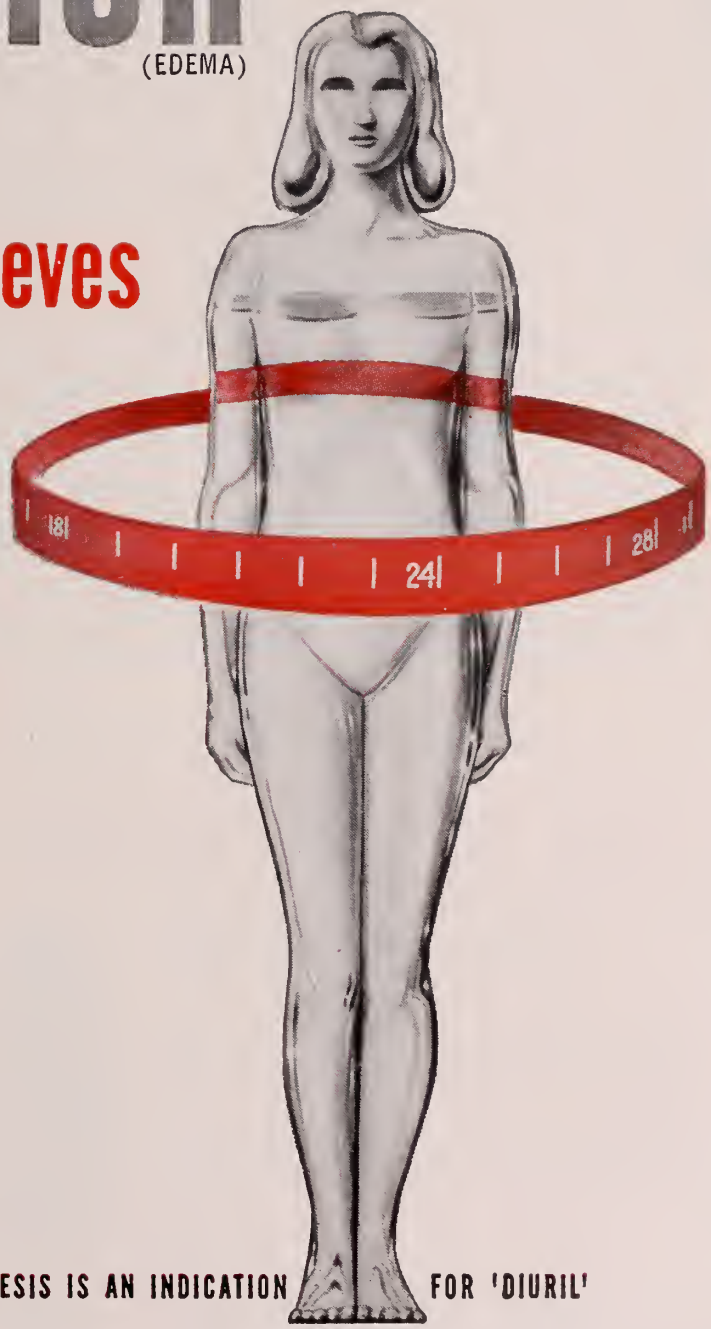

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references:

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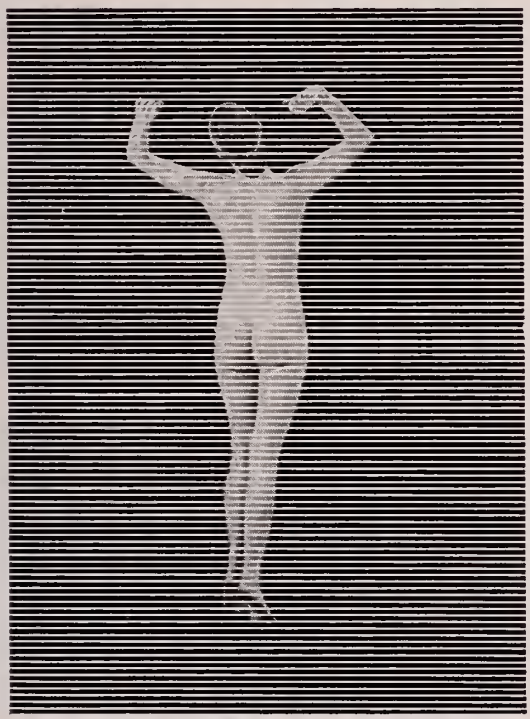

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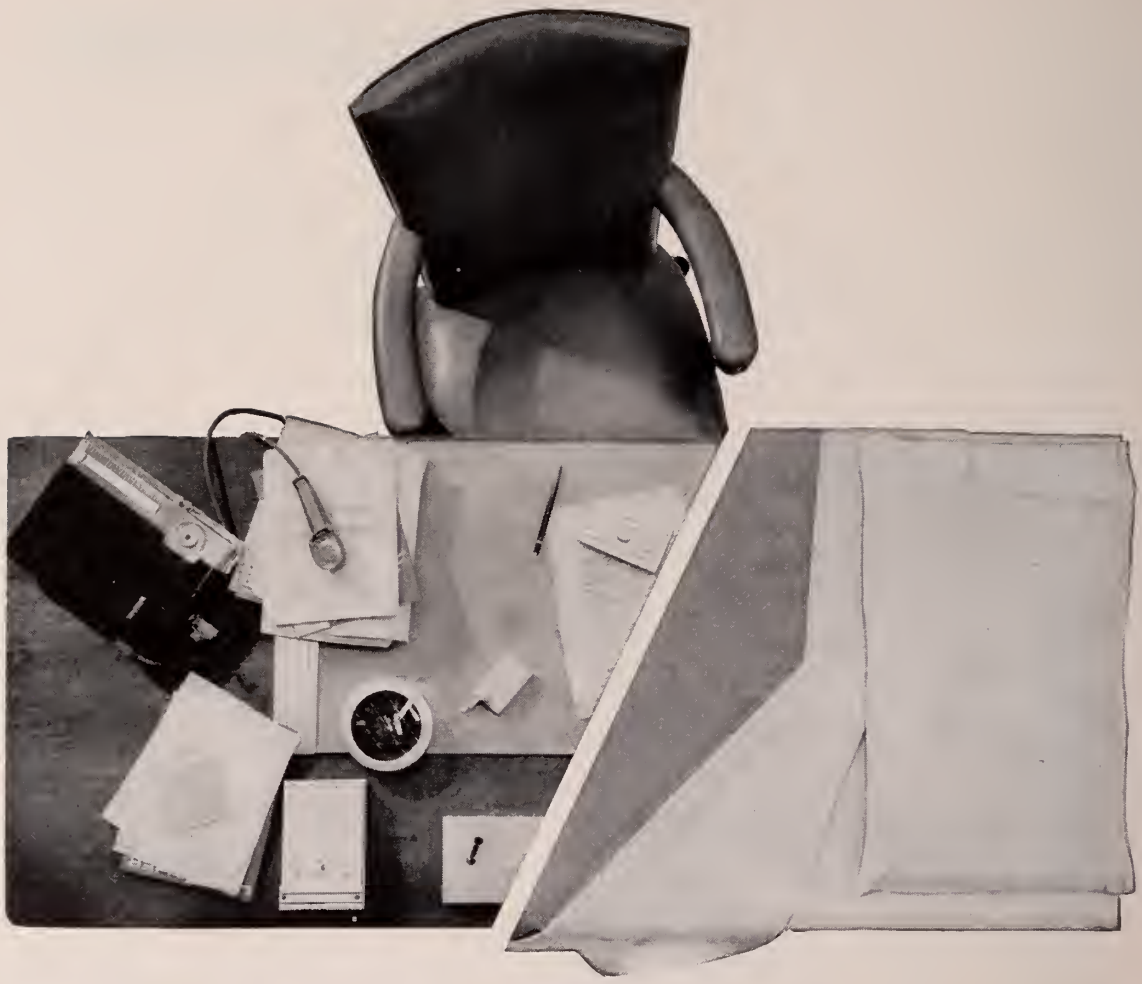

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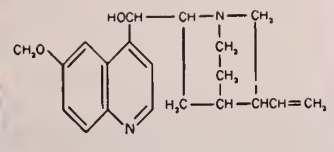

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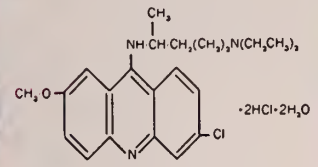

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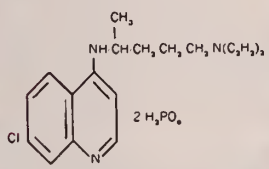

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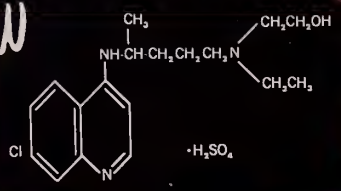

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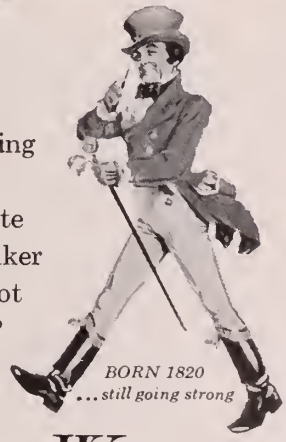

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2. Baird, H. W., III: A comparison of Meprospan (sustained action meprobamate capsule) with other tranquilizing and relaxing agents in children. Submitted for publication, 1958.

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usually within 5-15 minutes

LASTS LONGER...
usually for 6 hours or more

MORE THOROUGH RELIEF...
permits uninterrupted sleep through the night

RARELY CONSTIPATES...
excellent for chronic or bedridden patients

and now... **NEW**

Percodan®-Demi

VERSATILE

New "demi" strength permits dosage flexibility to meet each patient's specific needs. PERCODAN-DEMI provides the PERCODAN formula with one-half the amount of salts of dihydrohydroxycodeinone and homatropine.

AVERAGE ADULT DOSE: 1 tablet every 6 hours. May be habit-forming. Available through all pharmacies.

Each PERCODAN* Tablet contains 4.50 mg. dihydrohydroxycodeinone hydrochloride, 0.38 mg. dihydrohydroxycodeinone terephthalate, 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. phenacetin, and 32 mg. caffeine.

Literature? Write

Endo® **ENDO LABORATORIES**
Richmond Hill 18, New York

*U.S. Pat. 2,628,185

for adults and children

Prompt 4 way check of diarrhea

- Curbs excessive peristalsis
- Adsorbs toxins and gases
- Soothes inflamed mucosa
- Provides intestinal antisepsis

POMALIN

TRADEMARK

Liquid

EFFECTIVE ANTIDIARRHEAL

FORMULA: *Each 15 cc. (tablespoon) contains:*

Sulfaguanidine	2 Gm.
Pectin	225 mg.
Kaolin	3 Gm.
Opium tincture	0.08 cc.
(equivalent to 2 cc. paregoric)	

DOSAGE: Adults: Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

Children: ½ teaspoon (=2.5 cc.) per 15 lb. of body weight every four hours day and night until stools are reduced to five daily, then every eight hours for three days.

SUPPLIED: *Bottles of 16 fl. oz.*
Exempt Narcotic. Available on Prescription Only.

Winthrop LABORATORIES
New York 18, N. Y.

little How to win friends ...

The Best Tasting Aspirin you can prescribe.

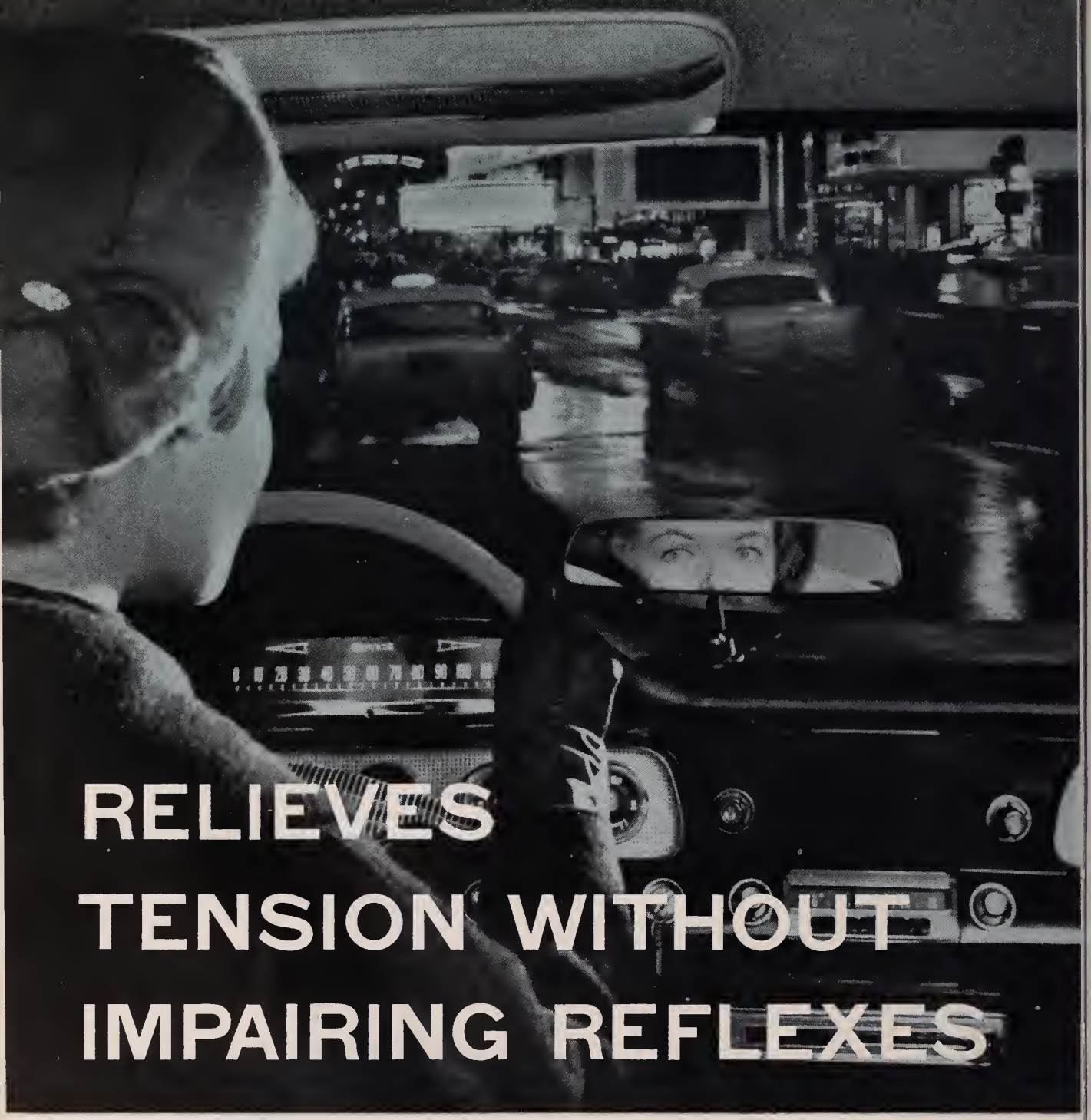
The Flavor Remains Stable down to the last tablet.

25¢ Bottle of 48 tablets (1¼ grs. each).

We will be pleased to send samples on request.

THE BAYER COMPANY DIVISION
of Sterling Drug Inc.

1450 Broadway, New York 18, N. Y.



"Even in double the usual dosage, [Miltown] produces no behavioral toxicity in our subjects as measured by our tests of driving, steadiness, and vision."*

Relieves anxiety, tension and muscle spasm in everyday practice

- with unexcelled safety
- without impairing autonomic function

Miltown®

meprobamate (Wallace)

Usual Dosage:
One or two 400 mg. tablets t.i.d.

Supplied:
400 mg. scored tablets, 200 mg. sugar-coated tablets, bottles of 50.

*Marquis, D. G., Kelly, E. L., Miller, J. G., Gerard, R. W. and Rapoport, A.: Ann. New York Acad. Sc. 67: 701, May 9, 1957.

WALLACE LABORATORIES, *New Brunswick, N. J.*

CM-7261

Mazola® Corn Oil...a palatable food effective in the management and control of serum cholesterol levels

Extensive clinical tests show that when the diet contains an adequate amount of Mazola Corn Oil, serum cholesterol levels tend to be normal... high blood cholesterol levels are lowered, normal levels maintained.

Fortunately for both physician and patient, Mazola Corn Oil is not only rich in unsaturated fatty acids, it is also a delicious food. It becomes an enjoyable and normal part of the patient's daily meals—no complicated or special diet is required.

Here is a therapy easy for you to prescribe, easy and pleasant for your patients to follow.

Nutritional authorities generally recommend that fats should provide no more than 30% of the total calories. In cholesterol-lowering diets from one-third to one-half of these fats should be unsaturated, such as in Mazola Corn Oil.

IN COOKING OR SALADS

Mazola Corn Oil is a superlative cooking oil as well as a delicious salad oil. Adequate amounts can be eaten daily—in a wide variety of salad dressings and in a great number of fried and baked foods.

MOST EFFECTIVE

Pure, clear, bland and odorless. Mazola Corn Oil is stable and dependable, providing the full measure of cholesterol-lowering unsaturated fatty acids characteristic of corn oil.

ECONOMICAL

Mazola Corn Oil is sold in grocery stores throughout the country, is available everywhere. Its comparatively low cost makes it as economical as it is effective.

CORN PRODUCTS
REFINING COMPANY

MAZOLA* CORN OIL is a rich source of unsaturated fatty acids. It can form a regular part of the diet without major changes in eating habits to provide an effective unsaturated oil as a part of the daily meals.

EACH TABLESPOONFUL OF MAZOLA CORN OIL PROVIDES NOT LESS THAN:

Linoleic Acid	7.4 Gm.
Sitosterols	130 mg.
Natural Tocopherols	15 mg.

TYPICAL AMOUNTS PER DIET

For a 3600 calorie diet	3 tablespoonsful
For a 3000 calorie diet	2.5 tablespoonsful
For a 2000 calorie diet	1.5 tablespoonsful

*Reg. U. S. Pat. Off.

NOW...A NEW TREATMENT

'CARDILATE'*

for THE PROPHYLAXIS OF ANGINA PECTORIS

'Cardilate' tablets shaped for easy retention in the buccal pouch

"... the degree of increase in exercise tolerance which sublingual erythrol tetranitrate permits, approximates that of nitroglycerin, amyl nitrite and octyl nitrite more closely than does any other of the approximately 100 preparations tested to date in this laboratory."

"Furthermore, the duration of this beneficial action is prolonged sufficiently to make this method of treatment of practical clinical value."

Riseman, J. E. F., Altman, G. E., and Koretsky, S.: Nitroglycerin and Other Nitrites in the Treatment of Angina Pectoris, Circulation (Jan.) 1958.

* 'Cardilate' brand Erythrol Tetranitrate SUBLINGUAL TABLETS, 15 mg. scored

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York

with new

CARTRAX*

PETN + ATARAX®

(PENTAERYTHRITOL TETRANITRATE) (BRAND OF HYDROXYZINE)

why PETN? *For cardiac effect:* PETN is ". . . the most effective drug currently available for prolonged prophylactic treatment of angina pectoris."[1] Prevents about 80% of anginal attacks.

why ATARAX? *For ataractic effect:* One of the most effective—and probably the safest—of tranquilizers, ATARAX frees the angina patient of his constant tension and anxiety. Ideal for the on-the-job patient. And ATARAX has a unique advantage in cardiac therapy: it is anti-arrhythmic and non-hypotensive.

why combine the two? *For greater therapeutic success:* In clinical trials, CARTRAX was demonstrably superior to previous therapy, including PETN alone. Specifically, 87% of angina patients did better. They were shown to suffer fewer attacks . . . require less nitroglycerin . . . have increased tolerance to physical effort . . . and be freed of cardiac fixation.

1. Russek, H. I.: Postgrad. Med. *19*:562 (June) 1956.

Dosage and Supplied: Begin with 1 to 2 yellow CARTRAX "10" tablets (10 mg. PETN plus 10 mg. ATARAX) 3 to 4 times daily. When indicated this may be increased by switching to pink CARTRAX "20" tablets (20 mg. PETN plus 10 mg. ATARAX.) For convenience, write "CARTRAX 10" or "CARTRAX 20." In bottles of 100.

CARTRAX should be taken 30 to 60 minutes *before* meals, on a continuous dosage schedule. Use PETN preparations with caution in glaucoma.

NEW YORK 17, NEW YORK
Division, Chas. Pfizer & Co., Inc.

*Trademark

"Since we've had him on NEOHYDRIN he can walk without dyspnea. I wouldn't have believed it possible a month ago."

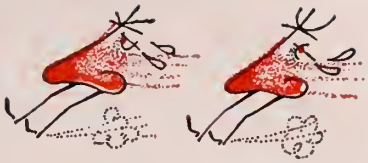
oral
organomercurial
diuretic

TABLET
NEOHYDRIN®
BRAND OF CHLORMERODRIN

LAKESIDE

24858

running noses . . .



and other hay fever symptoms

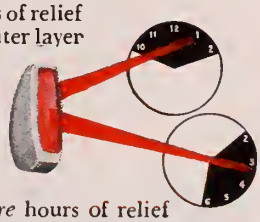
TRIAMINIC stops rhinorrhea, congestion and other distressing symptoms of summer allergies, including hay fever. Running nose, watery eyes and sneezing are best relieved by antihistamine *plus* decongestant action — systemically — with TRIAMINIC.

This new approach frequently succeeds where less complete therapy has failed. It is not enough merely to use histamine antagonists; ideally, therapy must be aimed also at the congestion of the nasal mucosa. Triaminic provides such effective combined therapy in a single timed-release tablet.

TRIAMINIC brings relief in minutes—lasts for hours. Running noses stop, congested noses open—and stay open for 6 to 8 hours.

Triaminic provides around-the-clock freedom from allergic congestion with just one tablet t.i.d. because of the special timed-release design.

first—3 to 4 hours of relief from the outer layer



then—3 to 4 *more* hours of relief from the inner core

Dosage: One tablet in the morning, mid-afternoon and at bedtime. In postnasal drip, one tablet at bedtime is usually sufficient.

Each timed-release TRIAMINIC Tablet contains:

Phenylpropanolamine HCl	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

TRIAMINIC FOR THE PEDIATRIC PATIENT

TRIAMINIC Juvelets*, providing easy-to-swallow half-dosages for the 6- to 12-year-old child, with the timed-release construction for prolonged relief.

*Trademark.

TRIAMINIC Syrup, for those children and adults who prefer a liquid medication. Each 5 ml. teaspoonful is equivalent to ¼ Triaminic Tablet or ½ Triaminic Juvelet.

Triaminic®

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska • Peterborough, Canada

Investigator

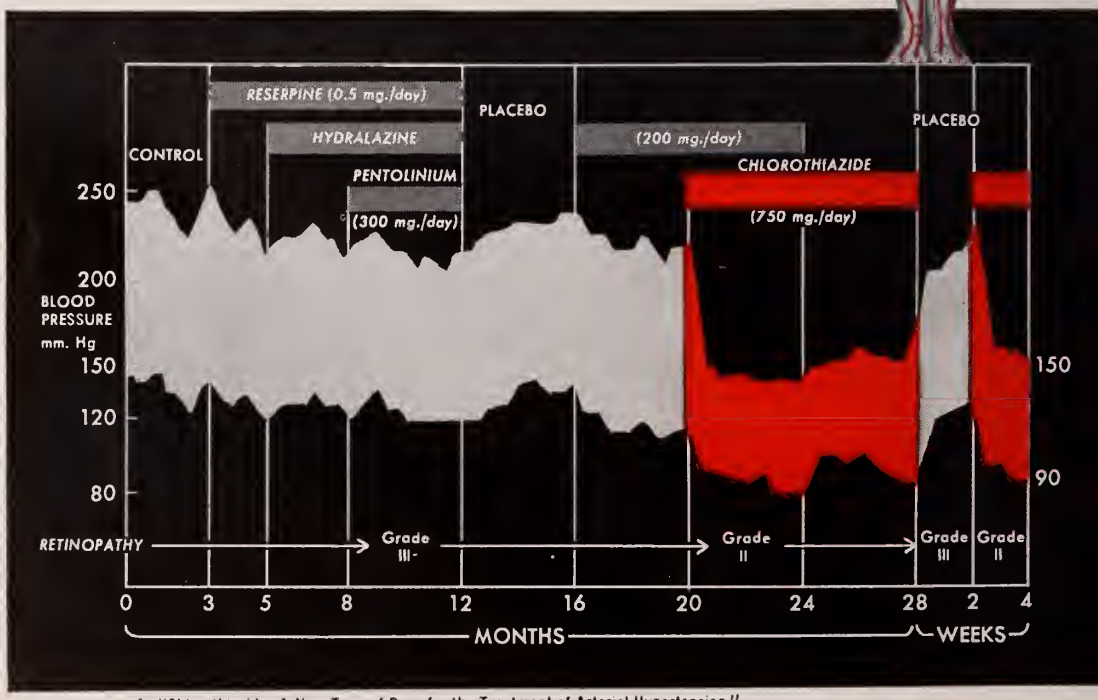
after investigator reports

Wilkins, R. W.: New England J. Med. **257**:1026, Nov. 21, 1957.

"Chlorothiazide added to other antihypertensive drugs reduced the blood pressure in 19 of 23 hypertensive patients." "All of 11 hypertension subjects in whom splanchnicectomy had been performed had a striking blood pressure response to oral administration of chlorothiazide." ". . . it is not hypotensive in normotensive patients with congestive heart failure, in whom it is markedly diuretic; it is hypotensive in both compensated and decompensated hypertensive patients (in the former without congestive heart failure, it is not markedly diuretic, whereas in the latter in congestive heart failure, it is markedly diuretic). . . ."

Freis, E. D., Wanko, A., Wilson, I. H. and Parrish, A. E.: J.A.M.A. **166**:137, Jan. 11, 1958.

"Chlorothiazide (maintenance dose, 0.5 Gm. twice daily) added to the regimen of 73 ambulatory hypertensive patients who were receiving other antihypertensive drugs as well caused an additional reduction [16%] of blood pressure." "The advantages of chlorothiazide were (1) significant antihypertensive effect in a high percentage of patients, particularly when combined with other agents, (2) absence of significant side effects or toxicity in the dosages used, (3) absence of tolerance (at least thus far), and (4) effectiveness with simple 'rule of thumb' oral dosage schedules."



In "Chlorothiazide: A New Type of Drug for the Treatment of Arterial Hypertension," Hollander, W. and Wilkins, R. W.: Boston Med. Quart. **8**: 1, September, 1957.

MERCK SHARP & DOHME Division of MERCK & CO., Inc., Philadelphia 1, Pa.

he effectiveness of 'DIURIL'

(CHLOROTHIAZIDE)

in

Hypertension

as simple as 1-2-3

1 **INITIATE THERAPY WITH 'DIURIL'.** 'DIURIL' is given in a dosage range of from 250 mg. twice a day to 500 mg. three times a day.

2 **ADJUST DOSAGE OF OTHER AGENTS.** The dosage of other antihypertensive medication (reserpine, veratrum, hydralazine, etc.) is adjusted as indicated by patient response. If the patient is established on a ganglionic blocking agent (e.g., 'INVERSINE') this should be continued, but the total daily dose should be immediately reduced by as much as 25 to 50 per cent. This will reduce the serious side effects often observed with ganglionic blockade.

3 **ADJUST DOSAGE OF ALL MEDICATION.** The patient must be frequently observed and careful adjustment of all agents should be made to determine optimal maintenance dosage.

SUPPLIED: 250 mg. and 500 mg. scored tablets 'DIURIL' (chlorothiazide); bottles of 100 and 1,000.

'DIURIL' is a trade-mark of Merck & Co., Inc.

Smooth, more trouble-free management of hypertension with 'DIURIL'

WHY SENSITIZE

in topical and ophthalmic infections

USE 'POLYSPORIN'®

brand

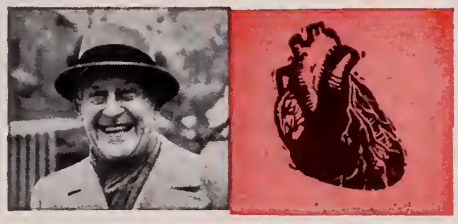
POLYMYXIN B—BACITRACIN OINTMENT

to insure broad-spectrum therapy with minimum allergenicity

For topical use: in ½ oz. and 1 oz. tubes.
For ophthalmic use: in ⅛ oz. tubes.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.

in each of these indications for a tranquilizer . . .



SR is a cardiac patient. His doctor put him on ATARAX because (+) it is an anti-arrhythmic and non-hypotensive tranquilizer.

Other tranquilizers added to PN's g. i. discomfort (he has ulcers). But now his doctor has him on ATARAX because (+) it lowers gastric secretion while it tranquilizes.

Asthmatic JL used to have frequent tantrums followed by acute bronchospasm. Her family doctor tranquilized her with ATARAX because (+) it is safe, even for children.

Senile anxiety and persecution complex dogged Mrs. K. until her doctor prescribed ATARAX Syrup. (+) It tastes good, and it's a perfect vehicle for Mrs. K's tonic.

Dosage: Children, 1-2 *10 mg.* tablets or 1-2 tsp. Syrup t.i.d. Adults, one *25 mg.* tablet or 1 tbsp. Syrup q.i.d.

Supplied: 10, 25 and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

. . . ATARAX® gives you an extra benefit

(BRAND OF HYDROXYZINE)

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New York 17, New York
Division, Chas. Pfizer & Co., Inc.

See anybody here you know, Doctor?

I'm just too much

AMPLUS®

for sound obesity management
dextro-amphetamine plus vitamins and minerals

I'm too little

STIMAVITE®

stimulates appetite and growth
vitamins B_1, B_6, B_{12}, C and L-lysine

I'm simply two

OBRON®

a nutritional buildup for the OB patient

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when anemia complicates pregnancy

And I'm getting brittle

NEOBON®

5-factor geriatric formula
hormonal, hematinic and nutritional support

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one capsule a day, for all treatable anemias

With my anemia, I'll never make it up that high

HEPTUNA® PLUS

when more than a hematinic is indicated

(Prescription information on request)

. . . solve their problems with a nutrition product from ROERIG

New York 17, New York
Division, Chas. Pfizer & Co., Inc.

WANTED

BY ALL DERMATOLOGISTS

A TOPICAL "METI" STEROID PREPARATION FREE FROM UNWANTED SENSITIZATION POTENTIAL

NAME **METI-DERM® CREAM 0.5%**

DESCRIPTION 5 mg. prednisolone, free alcohol, in each gram—nonstaining, water-washable base—exerts a therapeutic effect in presence of an exudate without being occlusive.

supplied: 10 Gm. tube.

Meti—T.M.—brand of corticosteroids.

SCHERING CORPORATION • BLOOMFIELD, NEW JERSEY

Schering

MD-J-218

. . . acts fast to provide unusually long-lasting relief

'Co-Pyronil' combines a long-acting and a short-acting antihistamine with a synergistic sympathomimetic. It usually begins to combat symptoms within fifteen to thirty minutes and eliminates them for as long as twelve hours. Thus you can give your hay-fever patients and other allergy victims remarkably complete relief on a dosage of only 2 or 3 pulvules daily.

* 'Co-Pyronil' (Pyrrobutamine Compound, Lilly)

Prescribe 'Co-Pyronil' in attractive green-and-yellow pulvules for adults; in tiny red pediatric pulvules or tasty suspension for children.

Each Pulvule 'Co-Pyronil' provides:

'Pyronil' (Pyrrobutamine, Lilly)	15 mg.
'Histadyl' (Thenylpyramine, Lilly) . .	25 mg.
'Clopane Hydrochloride' (Cyclopentamine Hydrochloride, Lilly) . . .	12.5 mg.

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.

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Lilly
POLIO VACCINE

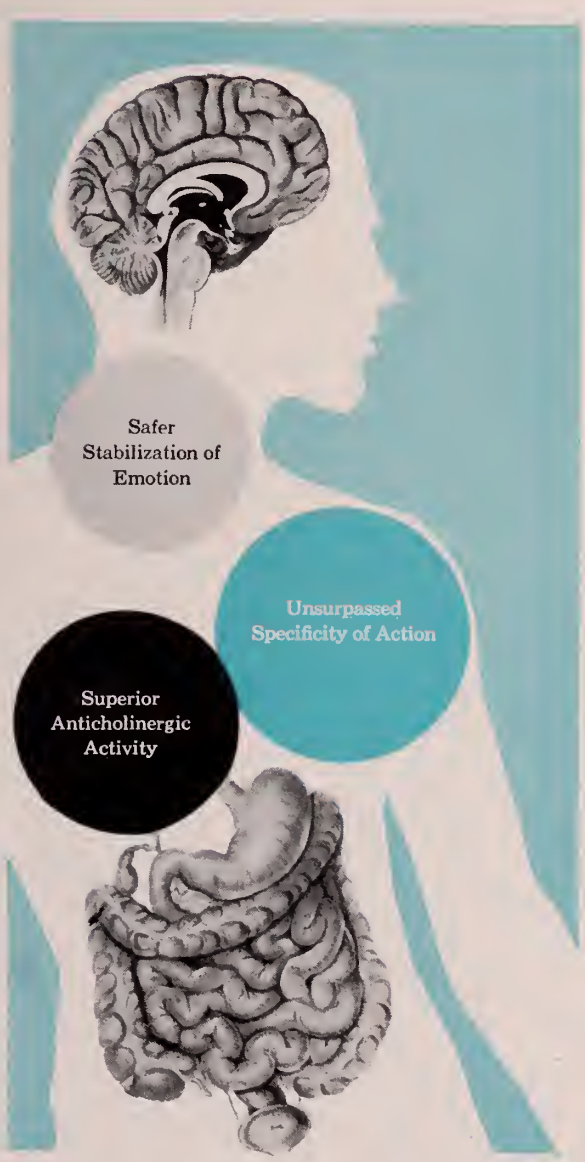
Controls Stress

Relieves Distress *in smooth muscle spasm*

new

Pro-Banthine® *with* Dartal®

– for positive relief of cholinergic spasm. – a new and safer agent for normalizing emotions.



PRO-BANTHINE WITH DARTAL offers you a new, specific and reliable control of visceral motor disorders, especially when these disorders are induced or aggravated by psychic tensions or anxiety.

Pro-Banthine has won wide clinical acceptance as the most effective drug for controlling gastrointestinal hypermotility and hypersecretion.

Dartal, a new phenothiazine congener, offers greater safety, flexibility and effectiveness in stabilizing emotional agitation.

The combination of each drug in fully effective doses in Pro-Banthine with Dartal gives a new means of approach to the medical management of functional gastrointestinal disorders mediated by the parasympathetic nervous system.

Specific Clinical Applications: Functional gastrointestinal disturbances, gastritis, pylorospasm, peptic ulcer, spastic colon (irritable bowel), biliary dyskinesia.

Dosage: One tablet three times a day.

Availability: Aqua-colored tablets containing 15 mg. of Pro-Banthine (brand of propantheline bromide) and 5 mg. of Dartal (brand of thiopropazate dihydrochloride).

G. D. SEARLE & CO., Chicago 80, Illinois.
Research in the Service of Medicine.

SEARLE

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(Terms end on December 31 of year indicated)

Stephen E. Gavin, Fond du Lac, 1958
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J. C. Griffith, Milwaukee, 1959
William D. Stovall, Madison, 1959

Alternates

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List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland–Bayfield–Iron	H. V. Sandin 220 Seventh W., Ashland	C. A. Grand 520 W. Second, Ashland	
Barron–Washburn–Sawyer–Burnett	C. J. Strang Barron	H. M. Templeton Barron	Second Tuesday 7:30 p.m.
Brown	George Nadeau 128 E. Walnut, Green Bay	Frank Urban 305 E. Walnut, Green Bay	Second Thursday°
Calumet	J. R. Goelz Brillion	J. W. Knauf Chilton	
Chippewa	B. J. Haines Cadott	R. L. Hendrickson 12 Third, Cornell	Second Tuesday
Clark	T. N. Thompson, Jr. Neillsville	H. M. Braswell, Jr. Owen	
Columbia–Marquette–Adams	H. A. Winkler 115 W. Chestnut, Pardeeville	T. S. Westcott Pardeeville	Every Third Month 7:00 p.m.
Crawford	O. E. Satter Prairie du Chien	H. L. Shapiro Prairie du Chien	Third Wednesday
Dane	T. J. Nerein 3710 Spring Trail, Madison	A. P. Schoenenberger 122 W. Washington, Madison	Second Tuesday Sept. through June
Dodge	R. F. Boock 119½ Front, Beaver Dam	G. G. Drescher 106½ Front, Beaver Dam	Last Thursday°
Door–Kewaunee	J. F. March 413 4th, Algoma	A. S. Lanier 3rd & Ellis, Kewanee	
Douglas	R. T. Anderson 1507 Tower, Superior	L. R. Rosin 2231 E. Fifth, Superior	First Wednesday°° Hotel Superior
Eau Claire–Dunn–Pepin	D. M. Willison 314 E. Grand, Eau Claire	K. E. Walter 131 S. Barstow, Eau Claire	Last Monday
Fond du Lac	John C. McCullough 20 Forest, Fond du Lac	R. W. Schroeder 330 Ledgeview, Fond du Lac	Fourth Thursday°
Forest	O. S. Tenley Wabeno	D. V. Moffet Crandon	
Grant	H. L. Doeringsfeld Platteville	H. W. Carey Lancaster	Last Thursday, March, June, Sept. and Nov.
Green	L. G. Kindschi 1770 13th, Monroe	J. A. Frantz Monroe Clinic, Monroe	

° Except June, July and August. °° Except July and August.

(Continued on page 42)

X-RAYS SHOW HOW ONE PYRIBENZAMINE® LONTAB®

relieves allergy all day or all night

The unretouched X-ray films show how Lontabs release medication in the digestive tract. So that the prolonged erosion of the Lontab core could be visualized by X-ray, subject was given 10 Lontabs, each containing 100 mg. of a radiopaque substance in place of Pyribenzamine.

With its unique formulation, the Pyribenzamine Lontab not only relieves allergy symptoms promptly, but sustains relief as long as 12 hours.

Special outer shell releases 33 mg. Pyribenzamine hydrochloride within 10 minutes.

Unique core releases approximately 18 mg. Pyribenzamine hydrochloride the 1st hour, approximately 50 mg. from the 2nd to the 12th hour.

SUPPLIED: Pyribenzamine *Lontabs* — full-strength — 100 mg. (light blue).

NOW AVAILABLE: Pyribenzamine *Lontabs* — half-strength — 50 mg. (light green) — for children over 5 and for adults who require less antiallergic medication.

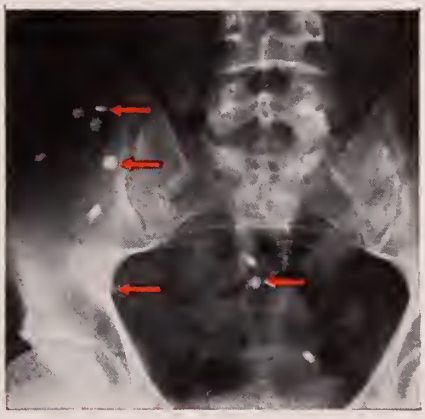
PYRIBENZAMINE® hydrochloride (tripelennamine hydrochloride CIBA)
LONTABS® (long-acting tablets CIBA)

2/2562MK

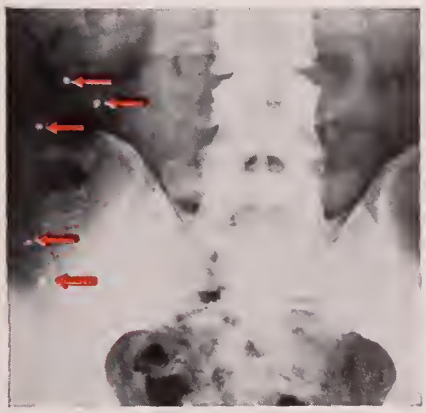
C I B A SUMMIT, N. J.

2 hours Lontabs are in the stomach and small bowel. Release of core substance is well under way.

4 hours Lontabs are in the ileum and cecum as core has steadily eroded.



8 hours Lontabs are still visible as substance of core continues to be released.



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Volume 57 JULY 1958 Number 7

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EDITORIAL COMMENT

Measuring Up to Responsibility

The medical schools across the nation are increasingly aware of acute problems in the development of an adequate clinical load to assure proper education for the medical students who will become the nation's physicians.

This problem as it relates to Wisconsin was brought into sharp focus by the House of Delegates in May when it accepted the report of the Society's Committee on Coordination of Medical Services. During the past year and a half the Committee has held repeated conferences with practicing physicians, and with officials of the University of Wisconsin Medical School and the University of Wisconsin Board of Regents.

These conferences produced a series of recommendations including expansion of the student health program, provision of medical care for undergraduate students and their families (if they so desire), special rates for obstetrical cases, establishment of a domiciliary facility for the unwed mother, and development of long range joint planning.

In the report the Committee emphasized that the entire membership of the State Medical Society should be aware of the problems facing the medical schools today. It urged that the individual physician "recognize and fully assume his share of responsibility in referring not only to the University of Wisconsin, but to Marquette University Medical School and other medical centers, such cases as may be properly referred, not alone for educational purposes, but to provide highly specialized services perhaps not else where so immediately available."

In making its recommendations the Committee expressed itself as "aware of the fact that any recommendations it makes must be conceived not only in light of the need of medical education, but in consideration of the distribution of medical and hospital facilities in the area centering around Madison.

"To do good to one and harm to the other would simply create another problem.

"But to find no solution would be failure to measure up to the responsibility assigned this Committee and through it, self-assumed by the entire medical profession."

Physicians should read the report of this Committee with care and heed well its words. The future of the profession and public health can be significantly influenced by the practicing physicians' ability to measure up to this responsibility.

A President's Remarks*

A complaint frequently hurled at physicians is that the medical profession is against progress, particularly in the methods of giving medical care. The public relations officer of a medical society taking a news item to a newspaper was asked by the editor, who knew of the officer's interest in medical affairs: "Well, what are the doctors against now?" He might have been told we are against the silly assumption that change is necessarily improvement, that we have always been against any plan aiming to take from us the care of the sick or come between the patient and his physician, that eighteen years ago we were against the inclusion by Blue Cross of medical service in its contracts—an inclusion which has cost the community many millions of dollars in increased costs for the maintenance of hospitals—and that we are against being exploited no matter under what guise the attempt to foist the exploitation may come.

Another question often asked in an accusing tone is: "Well, if you don't like our proposals what change do you suggest?" This fatuous query again is based on the foolish notion that change of itself means improvement. It also implies that an unacceptable proposal should provoke an alternative and not be considered refuted simply by well-founded objection.

Medicine is put on the defensive by attacks of this kind. As unjust as these tactics are they have been effective in harming the public relations of the profession. It is useless to point out that the sum total of physicians' efforts has given to this country the best health record in the world. To say we have advanced pure food and drug laws, inspired sanitary codes and given to patients the remedies research has developed for the treatment of disease gets us nowhere. The accusing questions still come on. "What are you going to do about this hospital insurance scheme?" "What are you going to do?"

We are not defenseless and the defense is simple and direct. We have only to ask in return: "Why do you want this change?" "How will you profit from it?" If the scheme comes from hospital administrators it will probably be one increasing their powers and prestige, leading to an increase in the size of their institutions and, most importantly to them, an increase in their salaries. Coming from the advocates of insurance schemes, public health and welfare workers the proposal often means an increase in their importance and also an increase in their incomes. There would be no objection to this self-seeking aggrandizement if it were not gained at the expense of someone else, in health schemes at the expense of the patient, community and physician.

A recent proposal is the so-called comprehensive medical care, a service to be given to the economic disadvantage of physicians. You may be sure its advocates have no intention of working in clinics, treating patients in the public wards of hospitals or caring for the sick in their homes. These services will be given, under their direction, by other physicians whose incomes will be lessened while the position of the advocates—their importance, prestige and incomes—will be enhanced.

So, for the protection of the patient and for our own defense we must examine carefully any plan purporting to improve health care and ask the proponent, "Why are YOU so interested? Who is your plan going to benefit besides YOU? Just what do YOU expect to gain in the way of prestige, power and income? And, at whose expense?" These questions would not harm the worthwhile cause, but if not properly answered would reveal an absence of altruism and the core of self-advancement motivating the proposer.

The question, "What's in it for YOU?", may sound cynical, but it is practicable. County medical societies must bear it in mind and ask it often.—JOHN T. FARRELL, JR.

* From Philadelphia Medicine Vol. 52, No. 11, October 12, 1957.

INTERNATIONAL COLLEGE OF SURGEONS TO HOLD TWO POSTGRADUATE COURSES

In response to requests, the United States Section of the International College of Surgeons has arranged with the faculty of the Cook County Graduate School of Medicine, Chicago, for the presentation of two postgraduate courses this year instead of one.

The first will be given July 7–19, and the second October 13–25. The courses will be conducted under the supervision of the attending staff of Cook County Hospital, Chicago.

The courses will include illustrated lectures, motion pictures, anatomy demonstrations, operative clinics, and practice surgery by the participants on anesthetized dogs. Consideration will be given not only to surgical techniques, surgical complications, and management of the surgical patient, but also to an intensive review of the basic sciences in relation to clinical surgery.

In addition to 20 hours of surgical anatomy on the cadaver, the program will include lectures and demonstrations on the following topics: gastric, pediatric, large and small bowel, anorectal, pancreatic, splenic, gallbladder, gynecologic, hernia, esophageal and thyroid surgery; physiology, intestinal obstruction, thoracic emergencies, cardiac arrest, hand injuries and infections, and abdominal injuries.

Additional information may be obtained from the Cook County Graduate School of Medicine, 707 South Wood Street, Chicago 12, or International College of Surgeons, 1516 Lake Shore Drive, Chicago 10.

OBITUARIES

Dr. H. C. Ladewig, 65, died March 11 at his home in Milwaukee.

A native of Milwaukee, Doctor Ladewig received his medical degree from Marquette University in 1918 and interned at Milwaukee County Hospital the following year. In addition to having a private practice he was clinical instructor in medicine at Marquette University. Because of failing health, Doctor Ladewig was forced into semi-retirement in 1949, leaving his practice altogether about a year ago.

He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Doctor Ladewig is survived by his widow, Lucy.

Dr. E. J. Schneller of Racine succumbed March 27 at the age of 64.

He was born in Sauk County in 1893 and was a 1925 graduate of Rush Medical College. From 1924 to 1925 he served an internship at West Suburban Hospital, Oak Park, Illinois. Immediately upon completion of his medical studies Doctor Schneller began a practice in Racine where he continued until the time of his death.

Doctor Schneller was a member of the Racine County Medical Society, the State Medical Society of Wisconsin, the American Medical Association, and the American Academy of General Practice. He held the post of president of his county society in 1948.

Among survivors are his widow, Hazel, and a daughter.

Dr. A. M. Ford, formerly of Roberts, passed away April 5 at a hospital near his Palmdale, California, home. He was 78 years of age.

He was born in 1879 at Waunakee. At the age of 22, Doctor Ford graduated from Marquette University after paying his expenses at school by working as a musician with bands and orchestras. His first practice was located at Windsor, but after a few years he was stricken with tuberculosis and moved to Wyoming to recuperate. Upon his return to Wisconsin he practiced at Roberts for four years, then went to Trout Lake, Michigan, to take over his late brother's practice. A second attack of tuberculosis struck Doctor Ford within a year and following recovery he returned to Roberts where he practiced until his health forced him to retire in 1956.

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DIMETANE Extentabs (12 mg. each, coated) provide antihistamine effects daylong or nightlong for 10-12 hours. Tablets (4 mg. each, scored) or pleasant-tasting Elixir (2 mg./5 cc.) may be prescribed t.i.d. or q.i.d., or as supplementary dosage to Extentabs in acute allergic situations. A. H. ROBINS CO., INC., Richmond 20, Virginia. Ethical Pharmaceuticals of Merit Since 1878.

*Sea food—source of highly potent allergens. Typical are: lobster; tuna; sturgeon roe; fish oil used to prepare leather, chamois, soaps; cuttlefish bone for polishing material and tooth powder; glues made from fish products.

Doctor Ford was a member of the Pierce–St. Croix County Medical Society, the State Medical Society of Wisconsin and its Fifty Year Club, and the American Medical Association.

Survivors include his widow, Margaret, a son and a daughter.

Dr. T. J. Snodgrass, a Janesville surgeon, was killed in an automobile accident April 7. He was 66 years of age.

Born in Baraboo in 1892, he attended Hamline College, St. Paul, Minnesota, and received his medical degree from the University of Minnesota in 1916. After serving his internship at the Minnesota University Hospital, he began practice in Janesville, assisting in the founding of the Pember–Nuzum Clinic. He acted as chief of surgery at the Clinic and at Mercy and Rock County Hospitals.

He was a member of the Rock County Medical Society, the State Medical Society of Wisconsin, the American Medical Association, the Wisconsin Surgical Club, a founder and past president of the Wisconsin Surgical Society, a member of the Western Surgical Society, and was certified by the American Board of Surgery.

Surviving are his widow, Nettie May; two sons, Thomas, Louisville, Kentucky, and William, Janesville; and two physician nephews, Drs. H. M. and Philip Snodgrass.

Dr. H. O. Caswell, a retired Jefferson county physician, died suddenly May 12 at the age of 84.

Doctor Caswell was born at Fort Atkinson in 1874. He graduated from Rush Medical College, Chicago, in 1897, after which he started medical practice in Fort Atkinson. He served that community for 51 years. Upon retirement in 1948, Doctor Caswell moved to Ellyn, Illinois, to live with a daughter, but returned to Wisconsin in 1950 and stayed at the Jefferson Hospital where he was active assistant resident physician. During World War I and II he headed the Jefferson county draft board and received a citation from President Roosevelt for this duty. He also held the post of surgeon for the Northwest Railroad for 48 years.

Memberships held by Doctor Caswell included affiliations with the Jefferson County Medical Society, life membership in the State Medical Society of Wisconsin, the Society's Fifty Year Club, and the American Medical Association. He served twice as president and 15 years as delegate of the county society.

Two daughters survive.

In a recent 140-patient study[1] DIMETANE gave "more relief or was superior to other antihistamines," in 63, or 45% of a group manifesting a variety of allergic conditions. Gave good to excellent results in 87%. Was well tolerated in 92%. Only 11 patients (8%) experienced any side reactions and 5 of these could not tolerate any antihistamines.

Robins

1. Thomas, J. W.: Ann. Allergy 16:128, 1958

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(Continued from page 36)

List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Green Lake–Waushara	G. G. Mueller Princeton	J. C. Koch Berlin	Last Thursday, every other month starting in Jan.
Iowa	C. L. White Mineral Point	E. J. Hohler Mineral Point	First Thursday following first Monday
Jefferson	E. E. Burzynski 113 N. Third, Watertown	E. P. Schuh 706 Madison, Watertown	Third Thursday*
Juneau	J. H. Vedner Mauston	J. S. Hess Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	W. C. Kleinpell 723 58th, Kenosha	Mr. L. F. Jost, Ex. Sec. Box 669, Kenosha	First Thursday* Elks Club
La Crosse	F. J. Gallagher 630 S. Tenth, La Crosse	J. B. Durst 1707 Main, La Crosse	Third Monday
Lafayette	R. E. Hunter Argyle	N. A. McGreane 123 E. Ann, Darlington	Last Tuesday
Langlade	R. W. Cromer 824½ Fifth, Antigo	J. E. Garritty Antigo	First Monday
Lincoln	F. C. Lane 401 W. Main, Merrill	J. D. Millenbah 121 S. Mill, Merrill	
Manitowoc	J. W. Steckbauer Suite 304, Savings Bank Building, Manitowoc	D. A. Kuljis 1606 Washington Two Rivers	Last Thursday
Marathon	J. V. Flannery 808 Third, Wausau	R. B. Larsen 510½ Third, Wausau	
Marinette–Florence	C. H. Boren Marinette	K. G. Pinegar 516 Houston, Marinette	Third Wednesday St. Joseph's Hospital
Milwaukee	S. A. Morton 3321 N. Maryland Milwaukee	L. R. Schweiger 324 E. Wisconsin Mr. J. O. Kelley, Ex. Sec. 756 N. Milwaukee, Milwaukee	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	H. A. Aageson 1113 Main, Oconto	C. E. Siefert Oconto Falls	
Oneida–Vilas	T. M. Haug 1020 Kabel, Rhinelander	Marvin Wright 1020 Kabel, Rhinelander	Monthly
Outagamie	George A. Behnke 240 W. Wisconsin, Kaukauna	George A. French 601 W. College, Appleton	Third Thursday* Elks Club
Pierce–St. Croix	P. S. Haskins River Falls	P. H. Gutzler River Falls	Third Tuesday
Polk	Stella I. Burdette Balsam Lake	L. J. Weller Osceola	Third Thursday 7:00 p.m.
Portage	W. C. Sheehan 755 Strongs, Stevens Point	W. A. Gramowski 319½ Main, Stevens Point	
Price–Taylor	W. W. Meyer 410 S. Second, Medford	J. J. Leahy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
Racine	L. M. Lifschutz 816 16th, Racine	W. H. Williamson 1101 Grand, Racine	Third Thursday
Richland	George Parke 323 S. Central Richland Center	L. M. Pippin Richland Center	First Tuesday Richland Hospital
Rock	V. S. Falk 5 W. Rollin, Edgerton	E. S. Hartlaub 2020 Milwaukee, Janesville	Fourth Tuesday
Rusk	M. L. Whalen Bruce	H. F. Pagel Ladysmith	First Tuesday
Sauk	M. F. Huth 203 Fourth, Baraboo	J. J. Rouse Reedsburg	Second Tuesday*
Shawano	L. W. Peterson Shawano	A. J. Sebesta Shawano	Third Tuesday
Sheboygan	J. A. Russell Random Lake	R. M. Senty 1011 N. Eighth, Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	D. S. Sharp 140 E. Main, Mondovi	Robert MacCornack, Jr. MacCornack Clinic, Whitehall	Fourth Tuesday
Vernon	H. E. Oppert 318 S. Main, Viroqua	R. A. Starr Viroqua	Last Wednesday
Walworth	J. B. Schrock Sharon	W. C. Woods 607 Walworth, Delavan	Second Thursday*
Washington–Ozaukee	J. F. Walsh 125 E. Main, Port Washington	V. V. Quandt 57 S. Main, Hartford	Fourth Thursday
Waukesha	James V. Bolger, Jr. 102 E. Main, Waukesha	Philip Wilkinson 618 W. La Belle, Oconomowoc	First Wednesday
Waupaca	Owen Larson Clintonville	H. S. Caskey Clintonville	
Winnebago	P. S. Emrich 456 Mt. Vernon, Oshkosh	G. B. Hildebrand 59 Racine, Menasha	First Thursday
Wood	W. L. Nelson 480 E. Grand Wisconsin Rapids	J. R. Heersma 650 S. Central, Marshfield	Four times a year

* Except June, July and August.

THE MEDICAL FORUM

MDS MUSTERED ALL FORCES FOR TORNADO VICTIMS

Teamwork Praised When Medical Units Unite to Treat 350 Injured Persons

COLFAX, WIS.—The full role of area physicians in the wake of the vicious tornado which struck western Wisconsin June 4 may never be known.

No less than five separate twisters wreaked their havoc on a line extending from Woodville to Thorp early in the evening. The two major municipalities hit hardest were Colfax and Chippewa Falls.

Who were the doctors who did the most in this disaster? Who were the heroes?

Dr. Rex E. Graber, Chippewa Falls, District 7 health officer, answered these questions thusly:

"All of them. They all played major roles. The team work shown by the doctors, nurses, orderlies and other ancillary personnel was carried out with such calm efficiency that it almost seemed that this was not a disaster. The physicians and others merely did what they were trained to do and what they were expected to do.

"These people never forget, as sometimes the public does, that their prime purpose is to serve the common good and improve the health of mankind."

Here is the toll, of both human lives and property:

Dead	28
Hospitalized	145
Injured	350
Houses destroyed	259
Houses damaged	426
Farm buildings destroyed	173
Farm buildings damaged	706

The mass handling of the immediate disaster involved many folks other than MD's, according to Dr. Graber. As to how doctors organized, the experience at Chippewa Falls is of special interest.

SERVICES HALTED

The hospital there is in the outer fringe of the twister zone. As the storm struck, power lines were destroyed, and all operations were carried out under emergency lighting facilities. The auxiliary system of the hospital was amplified by a portable unit brought in by the Chippewa Falls fire department. Outgoing telephone service also was interrupted.

(Continued on page 50)

Sen. Wiley Asks More Concern For Handicapped

WASHINGTON — Only 4,974 of 45,000 disabled persons in Wisconsin are being assisted in vocational rehabilitation work, U. S. Sen. Wiley (R–Chippewa Falls) said in a report to the senate recently.

"We have a considerable backlog of handicapped who have not yet been employed," Sen. Wiley told his colleagues. "We are reaching only 11.7 per cent of all we should, and that's only a small fraction of the vast number who must still be rehabilitated.

"We cannot afford to allow to lie fallow the talents and abilities of a single human being who can contribute to our national strength. Hiring the handicapped is a good national policy. It is good business. We cannot allow individuals to rust, so to speak; to sit around relatively idle, feeling forgotten, neglected, unwanted."

The senator said he had received word from Dr. Carl N. Neupert, Madison, Wisconsin state health officer, that Wisconsin needed 2,300 new, or additional, hospital beds during the coming fiscal year, at a total estimated cost of $52,-400,000.

Dr. Neupert also indicated a need for flexibility in use of federal funds in order to meet changing needs, Sen. Wiley said.

REGULATION NEEDED

Congress should not recess, he declared, without taking constructive action relating regulation of food additives.

"It is essential," he said, "that there be adequate testing of all new chemicals added to foods to prevent any injurious effects. Our pure food and drug laws may need tightening with respect to certain cosmetics and similar drugstore items.

"How adequate are our laws and how adequately are they being enforced? Congress can hardly be unmindful of this problem."

NAME THREE TO WPS COMMISSION

MADISON—Three appointments to the State Medical Society's Commission on Medical Care Plans were announced by Dr. R. G. Arveson, Frederic, Council chairman, this month.

Drs. L. O. Simenstad, Osceola, a past president of the society; Eugene J. Nordby, Madison, and N. J. Wegmann, Milwaukee, were added to the 26-man group, which has Dr. E. M. Dessloch, Prairie du Chien, serving as chairman.

CHIRO DEVICES TO BE DESTROYED

MADISON—Nine "Neurolinometer" machines held by I. N. Toftness, Cumberland chiropractor, were ordered condemned by Federal Judge Patrick Stone recently.

Condemnation action against the devices was begun last January by U. S. Atty. George E. Rapp, who said federal Food and Drug Administration inspectors had found them to be misbranded.

Pamphlets accompanying the devices claimed them to be capable of measuring "nerve interference," determining partial dislocations of the spine, and preventing disease and improper stomach and kidney functions.

The machines, the F. D. A. officials said, were incapable of doing anything of the sort.

Toftness' attorney had asked a jury trial, but withdrew the demand in June.

Judge Stone authorized the use of the machines in educational exhibits by the F. D. A. for a year before their destruction.

Ask Integrated Community Service–Medical Attention in Care of Aged

MADISON—In providing good medical care programs for the homebound, there is need for integrated community service with interprofessional team play.

That was the conclusion drawn at a workshop on these programs at the annual Governor's Conference on an Aging Population, held here in June.

Chairman of the workshop was Dr. A. M. Hutter, Fond du Lac, who also serves as chairman of the State Medical Society's Division on Geriatrics.

In his workshop summary, Dr. Hutter stated:

"The approach to medical care programs for the homebound necessitates the development of plans for early detection of disease with early diagnosis and treatment, periodic physical and laboratory examinations, followup examinations, adequate nutrition and weight control.

"The physician is central to this program but needs the services of health related activities in the treatment of the total individual and his family. The plan supplies the patient home nursing, health supervision, physical and occupational therapy, homemaker services, social services and visiting nurses' service.

"FREE CHOICE"

"The team approach is advocated in this program which should be geared to maintain the individual in his own home. The principle of free choice of family physician and free choice of related health services is again stressed.

"The aging individual should be permitted to retain his identity in his own environment. Part-time housekeeping service under supervision of visiting nurse associations presents a problem in adequate financing. The attention to basic social and emotional needs is equally important.

"The mental aspect of againg presents different clinical entities which can be handled by rational diagnostic and treatment attitudes.

"The shortage of trained social workers and nurses makes it important for the legislature and private agencies to expand training funds and find means to make the job more attractive financially and otherwise, so that trained workers may be retained.

Dr. A. M. Hutter

"A means such as community councils must be found for developing the teamwork approach and for a better understanding of what the various specialties can offer. To facilitate care of old age recipients in their homes, the legislature should consider:

"A—changing the relative responsibility law to permit financial incentives for relatives who keep infirm aged in their homes;

"B—increasing or removing the $75 maximum grant so that assistance agencies will have greater flexibility in making provision for housekeeping and other non-medical services."

A workshop on the subject, "Health Education and Preventive Medical Care," brought recommendations that county medical societies and hospitals should give thought to formation of local cancer registries; and that the smear test program for early detection of cancer of the uterus, now in a limited number of counties, be extended to cover the remainder of the state as soon as practicable.

The workshop, under the chairmanship of Dr. Carl N. Neupert, state health officer, also recommended:

Development of screening techniques to find cardiovascular cases in the aged at an earlier date; development of facilities for treating chronically ill older patients closely coordinated with existing hospitals; that welfare agencies develop substitute family care plans (foster home care) for the aged in need of such arrangements, and study of more effective means to inform older persons of better nutritional and safety habits.

Dr. Gundersen Keynotes Aged Conference

MADISON—There is too much negative thinking pervading too much of present-day public opinion regarding our senior citizens, Dr. Gunnar Gundersen, La Crosse, said in keynoting the second annual Governor's Conference on Aging.

Dr. Gundersen, president of the A. M. A., said:

"Unless we do something about it, there's reason to believe that we shall experience a growing amount of physical and mental breakdown among the elderly, filling our hospitals and custodial institutions to overflowing.

"This is a problem for the entire community to face and solve. We must learn to think in terms of how well a man is rather than how sick he is. We must learn to find tasks an older worker can do, rather than let ourselves be guided by what he cannot do. Older people need allies in making themselves active and useful.

"From the standpoint of enlightened self-interest, we cannot afford to waste this rapidly increasing source of manpower."

Dr. Gundersen questioned the value of hospitalization in many cases, particularly for persons who are just a little disoriented, saying:

"We have evidence today that from 40 to 75 per cent of the elderly persons in state mental hospitals can be rehabilitated, if the proper services are available in their home community."

(Continued on page 45)

TRY AGAIN

MADISON — The Governor's Conference on Aging this year reiterated a recommendation that a special statewide commission on aging be established with a paid executive secretary.

A resolution, adopted by delegates, is similar to one approved at the first conference in 1956. However, the 1957 legislature took no action on the recommendation.

The proposed commission would include both professional and non-professional members, and not be limited to state agency representatives.

DR. WILLIAM D. STOVALL, Madison, described by speakers as "Wisconsin's most distinguished physician," was honored at a testimonial banquet in Madison in June. After 44 years service with the State Laboratory of Hygiene, most of them as director, Dr. Stovall retired July 1.

More than 250 friends and associates joined in paying public tribute to Dr. Stovall, who was credited with being a leader in the campaign to provide free and adequate laboratory assistance to physicians, towns, agencies and individuals and for making outstanding contributions in cancer research and detection procedures.

A $2,500 gift from the Dane County Medical Society, which arranged the testimonial, was presented to the State Medical Society to initiate a special landscaping project dedicated to Dr. Stovall at the state society headquarters in Madison. Dr. T. J. Nereim, Madison (center in picture), served as master of ceremonies. Dr. J. W. Fons, Milwaukee (at left), president of the State Medical Society, was present as was Dr. Gunnar Gundersen, La Crosse, new A. M. A. president, and other persons prominent in medicine and other professional fields.

Dr. Stovall's co-workers at the laboratory presented a portrait of him to be hung at the laboratory. A preliminary copy of the painting is held by Dr. Stovall in the picture above.

Other speakers included Drs. H. Kent Tenney, Karver L. Puestow and John Z. Bowers, Madison, and Mr. Wilbur Renk, Sun Prairie, of the Wisconsin Board of Regents.

Dr. Stovall expressed his gratitude by simply saying "This has been superb."
—Rolf Lunde Photo

DR. GUNDERSEN . . .

(Continued from page 44)

He also observed that the ideal place for the elderly is in their own homes; that special housing for the aged, such as nursing homes, is a critical medical problem; that there is a growing need for trained direction and personnel in providing services to the aging, and that regular medical examinations would eliminate much illness in later years.

The day is near, Dr. Gundersen continued, when physical and mental deterioration will no longer be an inevitable part of the aging process, and "our greatest challenge lies not in how many years we can stay alive, but in the life we can put in those years."

Gov. Thomson, welcoming the delegates, asked for suggestions and ideas to help meet the needs of Wisconsin's growing older population.

He listed four conference aims: to determine the needs, to study the current opportunities, to hear the experiences of successful programs, and to set a course for the future.

"There is a great challenge for us to help uphold the dignity of our older citizens," the chief executive said. "They now comprise 9.1 per cent of our total population, and are a resource almost completely untapped. They are just waiting for us to present opportunities for active participation in community affairs.

"Let's push vigorously for programs for the betterment of these folks. Your state government stands ready to help whenever and wherever possible."

OSHKOSH STATE CHOICE OF 11

OSHKOSH—At least 11 Wisconsin physicians put in all or part of their undergraduate work at Wisconsin State College, Oshkosh, before going on to medical school.

Oshkosh graduates include Drs. Clair M. Flanagan and James C. McCullough, Fond du Lac; John A. Heraty, Milwaukee; George P. Dempsey, South Milwaukee; William C. Maas, Rio; Lester O. Mastalir, Burlington and Harvey Monday of Oshkosh.

Taking part of their college work at Oshkosh were Drs. Harold J. Danforth, Charles H. Behnke and Nyal M. Scheuermann, Oshkosh, and George A. Behnke of Kaukauna.

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RACINE BOARD ASKS STUDY ON COUNTY CLINIC

RACINE — The Racine County Board recently directed its Health and Hospitals Committee to study the possibilities of a county clinic to provide medical care for welfare and relief recipients now treated by private physicians.

The committee was asked to investigate the possibilities of setting up a diagnostic and treatment center in conjunction with the county institutions.

Welfare Director Edwin Affolter said that three physicians, to be paid fulltime by the county, would probably be required to staff the proposed center. One of them would have to be a surgeon, he said. A member of the board, however, said that in some areas where such clinics are operated, members of the local medical society perform surgery as a public service.

Peter Berres, committee chairman, said a clinic located at the institutions, west of the city, might not be convenient and that a location in the city might be preferable.

In another action, the board voted to continue negotiations with the Racine County Medical Society on a new fee schedule. The society's newest offer, to discount all items on a proposed new rate chart by 20 per cent, was rejected by the board.

The schedules, required by the state, are used by the county's welfare and social service departments to pay physicians for medical services they render to persons receiving public assistance.

V. V. Beers, of the village of Rochester, said the society's proposal was "out of line" with charges made by doctors in Kenosha, Walworth and Waukesha counties to their county governments.

The proposed fee schedule for Racine County would boost charges from $3 to $5 for office calls, $4 to $7 for daytime house calls, and night-time calls from $6 to $10.

Affolter told board members that his agency and the social service office spent $65,000 for medical services in 1957. He estimated that the increases would mean an additional cost to the county of $22,000 to $26,000 a year.

KIEL, WIS.—Guest of honor at a testimonial dinner recently was Dr. Daniel F. Nauth (left) who was cited for 51 years of medical practice in this eastern Wisconsin community. Taking part in the program were Dr. Robert J. Samp (second from left), of Madison, speaker for the evening; Dr. J. A. Russell (second from right), Random Lake, president of the Sheboygan County Medical Society, and State Sen. A. A. Laun of Kiel, master of ceremonies. More than 300 neighbors and patients of Dr. Nauth attended. Dr. Russell presented a citation from the State Medical Society, and Dr. Nauth also received a citation and a life membership plaque from the Kiel Chamber of Commerce and an achievement award from the Kiel Kiwanis Club. Toasts were presented by S. W. Zielanis, Kiel superintendent of schools; Edgar Thiessen, director of the Kiel Municipal Band; George F. Mattes, Rockville, a boyhood friend of Dr. Nauth, and Eugene M. Thieleke, Kiel, one of the first babies delivered by the beloved Kiel physician 50 years ago.
—Reische Studio Photo

In a letter to the board, Dr. Leo M. Lifschutz, Racine, president of the county society, said it was his understanding a 20 per cent discount would be accepted. He said his group was accepting the discount because of hardships the full schedule would work on the county's already-adopted 1958 budget.

Rex Capwell, village of North Bay, said there has been a 23.8 per cent cost of living increase and that by comparison the proposed fee schedule "doesn't look so bad." He voted against rejection.

The new schedules, Capwell added, include new medical and surgical procedures which, because they can cut hospital costs, constitute a savings in the long run. He asked for a long-range program, tieing the fees in with the cost of living and providing for periodic renegotiation strictly on the basis of new procedures which are developed.

DOCTOR!

Urge your patients to listen to the MARCH OF MEDICINE weekly radio program. FORTY-SIX STATIONS!

Show Emergency Hospital Units

MADISON—A unit of the State Office of Civil Defense 200-bed emergency training hospital is making a tour of storage sites in a number of Wisconsin communities this summer.

Purpose of the tour is to enable state medical personnel to explain to local health officials the use and functions of various items included in the portable hospital's equipment with which they may be unfamiliar. Also, civil-defense-minded citizens will have an opportunity to see what the unit consists of and learn how it will function in a disaster.

The 34 units located at selected points in the state are sealed in their cases and can only be opened in event of an emergency.

Visited in recent weeks were Richland Center, La Crosse, Portage, Wautoma, Antigo and Ripon. Other communities will be visited next fall.

PLAN COLLEGE HEALTH CONVO

MILWAUKEE — Six physicians and Gov. Vernon S. Thomson will take leading roles in the Wisconsin Conference on College Health, to be held here Oct. 10–11.

The chief executive will speak on the subject, "Health, Wisconsin's Number One Asset."

Dr. O. P. Rowlands, Madison, director of University of Wisconsin Student Health Services, will head one workshop session, and Dr. W. D. Stovall, Madison, director of the State Laboratory of Hygiene, will be a discussion leader in another.

Dr. John S. Hirschboeck, Milwaukee, dean of the Marquette University School of Medicine, will moderate an administrator's panel.

Other physician–participants will include Dr. W. W. Bauer, Chicago, director of the A. M. A. Bureau of Health Education; Dr. Dana L. Farnsworth, Boston, director of health services, Harvard University, and Dr. Ralph I. Canuteson, director of student health services, University of Kansas, Lawrence.

Main objective of the session is to determine the scope of the college health program, and whose concern is it?

Physicians, educators, parents and students are invited to attend the conference, which will be held at the Marquette Student Union.

Miss Junghans Wins Assistants' Honor

ELKHART LAKE, WIS.—Geraldine Junghans, of Jackson (Washington County), is Wisconsin's "Medical Assistant of the Year."

The choice was made at the fourth annual meeting of the Wisconsin State Medical Assistants Society in June.

Miss Junghans, employed in the office of Dr. J. P. Albrecht, was chosen on the basis of her devotion and service to her physician, and on her record of service to her county and state medical assistant societies.

Violet Owen, Stoughton, was elected president, and Violet Wendt, Milwaukee, president-elect. Other new officers:

Julia Logerquist, Sturgeon Bay, corresponding secretary; Mrs. Alice Brown, Beloit, recording secretary, and Mrs. Margaret Russell, Waukesha, treasurer.

The next meeting will be held in Eau Claire June 5–7, 1959.

OCCUPATIONAL SKIN DISEASES COSTLY

MILWAUKEE — Dr. Harry E. Foerster, Milwaukee, told the annual Congress on Industrial Health that occupational skin diseases involves a considerable financial loss every year.

This, he said, was estimated, as long ago as 1945, to exceed $100,000,000 in an average year. These cases represent about 30 to 40 per cent of occupational disease incidence. Most cases of occupational dermatitis, observed in industrialized areas and excluding mechanical injuries, are examples of various forms of dermatitis venenata. Approximately 80 per cent of the latter cases are caused by contact with primary irritants of which there are a great number and 20 per cent are caused by sensitizing agents.

Reuben G. Knutson, Madison, chairman of the Industrial Commission, said that if there is a relationship between "excessive work" and heart attacks, industrial commissions need to know how long after the performance of that "excessive" physical effort should it be before the symptoms (of heart attack) manifest themselves.

AGREE, DISAGREE

"We know," he said, "there are certain items in casual relationship upon which doctors honestly disagree, but frankly there are others where it becomes rather disgusting to us that we have to continue month after month, year after year, listening to these controversial medical issues.

"Doctors have agreed on many items in the way of diagnosis, in the way of treatment . . . anything having to do with the elimination of pain and suffering that is the lot of humanity. As long as you can agree upon these procedures, isn't it possible and probable that you can sit down and agree upon some guideposts that will be of material value to administrators of workmen's compensation on the relationship of work and heart attacks?"

Dr. O. A. Sander, Milwaukee, told Knutson that the A. M. A. currently has no committee working on the development of criteria of causal relationship in cardiovascular cases. They do, however, have a committee working on a very important problem in cardiovascular diseases—that of permanent impairment, the physician said, adding:

FOR MDS . . .

"This committee (on Medical Rating of Physical Impairment), of which I happen to be a member, is developing this guide primarily for use by physicians. But it also will be of interest to workmen's compensation administrators and others concerned with any type of program of disability evaluation.

"However, until more factual data are available, it is not likely that the A. M. A. will attempt to develop a guide on the causal relationship of work and heart disease."

PLEASE NOTE!

A report of the meeting of the A. M. A. Congress on Industrial Health, based on newspaper accounts, was carried in the February issue of The Wisconsin Medical Journal. Dr. O. A. Sander, Milwaukee, a member of the A. M. A. Council on Industrial Health, called attention to several inaccuracies in these accounts which are corrected in this article.

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A.M.A. Survey Shows MD's Use Assistants in Semi-Technical Work

CHICAGO—An A. M. A. survey summary stated recently that physicians are not making maximum use of their extensive training when they perform unnecessarily semi-technical and business-office activities.

The survey was compiled by Mr. Harold Mickelson, Ed. D., Kirksville, Mo., educator, to determine the scope of duties, training and the role of the medical assistant on the medical team. Replies to a questionaire were received from 428 M.D. offices.

The study listed duties in the doctor's office into three groupings:

Highly technical medical activities: Relate to examination or treatment of patients, of such a complicated or important nature that, under normal conditions, only physicians can perform them.

Semi-technical medical activities: Those activities which, under normal conditions, may be performed by trained medical assistants, but always under the direction of a physician.

Business-office activities: Of routine clerical and management nature, engaged in for the purpose of conducting the business affairs.

Findings showed that almost all of the 428 assistants handled general assignments related to business-office details. Mr. Mickelson said the assistants included regular secretaries, registered nurses and laboratory technicians.

In the semi-technical field, 201 assistants draped patients for examinations, 182 weighed patients, 266 assigned and conducted patients to examination rooms, 167 took temperatures, 108 took pulse rates, 140 measured patients, 50 determined basal metabolism rates, 45 operated electrocardiograph machines, 36 took and developed x-ray pictures, 70 took blood pressures, 40 gave visual-acuity tests, 121 assisted with minor surgery, 55 placed patients under a diathermy machine, 93 applied surgical dressings, 113 removed such dressings, 7 repaired or adjusted glasses, 94 gave intramuscular injections, 86 gave hypodermic injections, 38 made or assisted in making house calls, 28 gave vaccinations, 7 assisted with major surgery.

OF MUCH AID

Mr. Mickelson said:

"This conclusion can be drawn: a highly competent secretary can relieve a physician of performance of all or nearly all business-office and semi-technical medical activities connected with his medical practice. But of course, he is responsible for making certain that all activities in his office are performed properly. Therefore, he must exercise direct or indirect supervision over each activity in his office."

One physician interviewed during the survey commented:

"There is almost no ceiling to the responsibility (business-office and semi-technical) that an outstanding secretary can take over for the doctor. Some secretaries have grown on the job to the point that the doctor would be completely lost without them. The job offers a tremendous opportunity to the qualified girl who wants a really important job and who will work at it."

TRAINING IMPORTANT

Mr. Mickelson said most doctors were convinced that the training of their assistants should be in the hands of a qualified business college because much of their work is of a business nature, and that they preferred to train them in semi-technical assignments themselves.

(The Wisconsin State Medical Assistants Society, aided by the State Medical Society's Council on Medical Service, currently is working to set up one or more schools to train assistants in Wisconsin).

HUDSON, WIS.—Dr. J. E. Newton, who began practice here in 1917, is this community's "man of the year."

His neighbors recently presented him and Mrs. Newton with a purse containing sufficient funds for a trip to Europe this summer. They also presented him with two plaques attesting to their esteem of the veteran practitioner.

Earlier in the year, the Hudson Kiwanis Club honored Dr. Newton as the "Outstanding Citizen." He was cited as the man who "made Hudson a better place to live."

Accepting the honors accorded him this spring, Dr. Newton said he was "totally unprepared . . . I don't know whether to laugh or cry. I feel like the winner of the $64,000 quiz, only this means much more to me. No one can tell me there's no Santa Claus. Thank you from the bottom of my heart."

Dr. Newton was born in Detroit Lakes, Minn., but he grew up in Elwood City, Pa. He attended Valparaiso (Ind.) University and Loyola University in Chicago, where he received his M. D. degree. He practiced two years in Athens, Tenn., and a year in Windsor, Wis., before coming to Hudson 41 years ago.

He served as Hudson's mayor from 1934 to 1950, and has been active in church and fraternal organizations.

With Dr. Newton (third from right) in the picture above are (left to right): Dr. George J. Hopkins, Hudson, representing the Pierce—St. Croix County Medical Society; Mr. Fred Kermott of the Kiwanis Club; Mrs. Newton, and Mr. Edward Rock of Hudson.
—Anderson Photo

WARNING: BE WARY OF TELEPHONE SOLICITATIONS!

MADISON—Beware of telephone solicitors!

That was the warning sounded by the Madison Chamber of Commerce recently.

Each week, the chamber said, "various local businesses are solicited by telephone by persons who leave the impression they are local members of worthy organizations. In some instances they pressure by implying repercussion in case of refusal. Misrepresentation flows easily.

"Many and sundry are their methods and wiles. Most of the solicitors are professionals, and not local people. Most of the money expended for these types of 'advertising' projects goes out of town."

What to do?

Accept no advertising solicitation or orders over the phone.

Pay no bills unless you have a contract in writing, negotiated in advance.

Demand to see the solicitation committee approval card before you consider requests for tickets, prizes, donations, etc.

Call your local chamber of commerce or city fathers when in doubt.

A "firm" swept into Madison recently and sold by telephone "bulletin board" space. Investigation showed misrepresentation of themselves, their product and their purpose.

Seek Candidates for Advanced Nurse Study

NEW YORK—Applicants for fellowship study in nursing are being sought by the National League for Nursing Inc., 2 Park avenue, New York 16.

There is a growing need, the league said, for nurses prepared to accept leadership positions in administration and education and to engage in research in the field of nursing.

The league's fellowship program seeks applicants who will make significant contributions to nursing after a period of advanced study.

Information is available at the league office.

Plan Symposium On Formation and Disease of Bone

MADISON — The State Medical Society's Charitable, Educational and Scientific Foundation will be one of the sponsoring organizations when the fifth annual symposium of the A. M. A. Council on Foods and Nutrition is held here Oct. 16.

Other sponsors will include the University of Wisconsin Medical School and the Dane County Medical Society.

The symposium will be devoted to factors involved in formation and disease of bone. Faculty members will include Drs. D. M. Angevine, Lester W. Paul and J. J. Lalich, of the Wisconsin Medical School; Profs. David W. Smith, F. M. Strong, Harry S. Steenbock and Hector F. DeLuca, of the University of Wisconsin; Dr. I. V. Ponseti, University of Iowa; Dr. W. D. Armstrong, University of Minnesota and Mr. Willard Libby of the Atomic Energy Commission.

No registration fee will be charged. Credit in Category I is expected to be granted to members of the American Academy of General Practice.

FOR YOUR INFORMATION!

The government, while slow to acknowledge anything wrong with the Social Security system, underestimated the demand for benefits. Women who could obtain benefits at 62, 63, and 64 decided to do so even if the payments were less than they would be at 65. Farmers suddenly turned out to be older than expected. Some began to pay social security taxes on reported income of $4200 which exceeded their income in prior years. Then they applied for benefits after paying taxes for six quarters. Many people who had retired and were well beyond 65 years of age, dug up jobs for themselves and paid social security taxes for 18 months, thereby qualifying for benefits of from $30 to $108.50 monthly for life. Social security experts in making their cost projections underestimated the ingeniousness of the American people when federal giveaways are as widely advertised as are social security benefits.

MADISON—Fifty-three preceptors, from all sections of Wisconsin, came here in June to attend the University of Wisconsin commencement, to escort graduates of the medical school at graduation, and to hear reports on obstetrics and gynecology, pediatrics, and the Wisconsin Medical School. Later they were guests at a gathering at the State Medical Society office. From left above: Dr. M. M. Baumgartner, Janesville, most recent appointed preceptor; Dr. John Z. Bowers, Madison, dean of the Wisconsin Medical School; Dr. Maurice L. Whalen, of Bruce, and Dr. Warner S. Bump, Rhinelander, who came the greatest distance to attend the session. Wisconsin is one of the strongest backers of the preceptorship program in this country, and one of the few that require preceptorship work prior to graduation.

—Rolf Lunde Photo

TORNADO . . .

(Continued from page 43)

Local doctors were mustered in modern Paul Revere fashion, using automobiles instead of a horse. One physician on his way home drove into the storm in time to see a rural home demolished and to rescue an injured person whom he transported to the hospital, necessarily making a wide detour to find unobstructed roads.

At the hospital the pre-conceived disaster plan operated smoothly, despite the utility setbacks. It was largely a repetition of a mock disaster rehearsal held a short time ago, in which make-believe victims had been used. This time, however, was in dead earnest. A receiving station just inside the ambulance entrance had to be moved further inside the building because of a high wind which was slow in subsiding.

In most cases, first aid attention was given to the injured. Some of them were placed in beds. In a few cases, more complete treatment was carried out at once, such as minor debridement and suturing, when possible without creating a line of unattended patients.

Fifty-four persons were treated at this hospital, of whom 19 were allowed to leave after being reexamined at a "discharge center." No dead-on-arrivals reached the hospital. One patient died within 12 hours of admission.

Only two of the 54 reached the hospital by ambulance. The populace literally transported its own victims in its own vehicles.

Even before the storm struck Chippewa Falls, WEAU (Eau Claire) was broadcasting for help of all kinds for the residents of Colfax which was hit 40 minutes before Chippewa Falls. Persons owning station wagons were asked to proceed to Colfax to help transport the injured. Soon there were so many on hand that a radio appeal asked others to stay home.

Colfax was the only point, Dr. Graber told the *Medical Forum*, from which injured persons were evacuated from a primary receiving station to treatment centers. Most of these went to Eau Claire. An early broadcast urged all doctors and nurses in western Wisconsin to rush to the hospital at Menomonie. The response, as might be expected, was excellent, although Menomonie physicians had the situation well under control at all times.

VA PLANS PROJECTS AT WOOD, TOMAH

WASHINGTON—The Veterans' Administration is calling for bids on 12 construction projects estimated to cost at least $4,200,000. These include remodelling improvements at military hospital installations at Wood and Tomah, Wis.

Dr. Graber said that in directing and applying first aid, sorting and evacuating the injured and otherwise leading efforts directed toward the comfort and safety of his sorely stricken community, Dr. O. M. Felland, of Colfax, did a terrific job of aiding and organizing medical and allied units. More than 150 injured were treated in this little town alone, many of them in the community hall where a first aid center was set up in a hurry. His colleagues arrived quickly to lend much aid.

Dr. Felland is the only M.D. in Colfax.

Public health problems arising from the situation were minimal. The Colfax water supply became temporarily polluted by back siphonage of the surface water after electricity was cut off and pressure lost. State Board of Health personnel immediately took protective action through chlorination.

WATER UNHARMED

It was providential that a state accredited water and milk testing laboratory located in Colfax was unharmed by the storm, thus enabling prompt control over safety of the water.

"There was 100 per cent cooperation on the part of everyone concerned in the disaster," Dr. Graber commented. "Even the patients cooperated.

"If you heard reports that the efforts of the physicians were outstanding, you heard correctly. There was prompt, efficient medical attention in Menomonie, Bloomer, Eau Claire. Colfax, Stanley and Chippewa Falls, and elsewhere, too."

It was not necessary to utilize the emergency 200-bed units provided by the civil defense office, although one was held in readiness for such need. The quick flow into area hospitals and the latter's ability to handle this flow resulted in a decision not to employ the emergency hospitals.

COOPERATION CODE RACINE TOPIC

RACINE—Misunderstanding between physicians and attorneys, concerning medical testimony, is the biggest single problem facing both professions.

That was the conclusion drawn by more than 100 physicians and attorneys who met recently to discuss an interprofessional code adopted several years ago by their respective state societies. The gathering was called to foster a closer personal acquaintanceship and understanding of mutual responsibilities.

Dr. J. C. Griffith, Milwaukee, who outlined code provisions from a medical standpoint, said physicians recognize their responsibility to present court testimony when called upon. However, they are often reluctant to do so, he said, because they are fearful of malpractice suits which might result, and they hesitate to disclose personal records of patients.

In discussing fee schedules, Dr. Griffith was asked if doctors would agree to establishing a minimum fee schedule covering court services. He said that most members of his profession dislike such schedules, preferring to set charges on what they believe the individual services are worth.

The lawyers were asked if it were in the bounds of ethics for a physician to advise accident victims to employ counsel. Alfred E. La France, Racine attorney, replied that a physician's suggestion for a patient to obtain counsel was proper. He warned that referrals to specific attorneys would place the physician in a position as a "chaser" for lawyers.

Dr. Leo M. Lifschutz, President of the Racine County Medical Society, attacked a proposal that chiropractors be licensed to use x-ray equipment. He cited a Kenosha County case in which the court held chiropractors could not use such equipment in the treatment of patients, saying:

"If the State Supreme Court upholds the Kenosha court's findings, chiropractors will attempt to lobby a bill through the legislature authorizing chiropractic x-ray licenses."

Atty. Jacob Weisman, Racine, was elected president of the Racine County Bar Association at this meeting.

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SOCIETY PROCEEDINGS*

Dodge

The Dodge County Medical Society held its May 29 meeting at Waupun Memorial Hospital. Included on the evening agenda was the appointment of committees for Geriatrics, Public Policy, and Communicable Disease. The members also discussed the county fee schedule, suggesting higher fees, and talked about athletic examinations, deciding that the present "herding method" used at school at one time is not adequate or satisfactory.

Outagamie

Fifty-two members of the Outagamie County Medical Society met April 25 at St. Elizabeth Hospital in Appleton for a special business meeting. Matters discussed were the school vision program and the resolutions to be submitted at the Annual Meeting. A report was also given by the cytology committee.

On May 15 the members met at the Elk's Club in Appleton. The meeting was held jointly with dentists and lawyers of the county with the purpose of hearing a speech delivered by Gov. Vernon Thomson.

Polk

"Interpretation of Cardiographs" was the subject chosen by Dr. Ben Sommers of St. Paul, Minnesota, when he addressed the Polk County Medical Society on May 15. Following the talk Mr. C. H. Crownhart reviewed some of the events taking place in conjunction with the State Society's Annual Meeting.

Price–Taylor

Drs. Thomas Rice and *Paul Noble* of the Marshfield Clinic presented a paper on "Uterine Cancer" at the May 22 meeting of the Price–Taylor County Medical Society. During the business session the following physicians were elected to office for the coming year: *W. W. Meyer*, Medford, president; *W. E. Niebauer*, Phillips, vice-president; and *James J. Leahy*, Park Falls, secretary–treasurer. The meeting was held at the Leahy Clinic in Park Falls.

* Physicians whose names are printed in italics are members of the Society.

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Sheboygan

Members of the Sheboygan County Medical Society were guests of the Kohler Company at their May 15 meeting. The program included an afternoon tour of the plant followed by dinner and a business meeting in the evening.

Dr. Harold Cook, director of medical services for Milwaukee County Institutions and Public Health Department and a member of the medical advisory committee to the State Civil Defense Commission, summarized the current civil defense and disaster planning, emphasizing the role of local doctors in this plan.

In action taken by the members, it was unanimously decided to publicly recognize and commend the excellent response of blood donors during the recent visit of the bloodmobile unit in their county. Decision was also made to continue sponsorship of crippled children clinics in the area.

Washington–Ozaukee

The Grafton Hotel was the site of the meeting of the Washington–Ozaukee County Medical Society held May 22. Guest speaker was *Dr. Donald Babbitt*, roentgenologist from Milwaukee. He talked on the use of radio-active materials.

Four high school students of the Washington–Ozaukee County area were honored with money awards and certificates for winning essays sponsored by the Association of American Physicians and Surgeons' Freedom Programs, Inc. This is the twelfth year of the annual event which promotes the idea of free enterprise and in particular the free practice of medicine as opposed to socialism.

Wisconsin State Urological Society

At the April meeting of the Wisconsin State Urological Society the election of officers was held. *Dr. Frank Hilpert*, Racine, was chosen president, *Dr. Ben Brunkow*, Monroe, was named vice-president; and *Dr. Donald W. Calvy*, Milwaukee, was elected secretary–treasurer.

Speakers on the program and their subjects were as follows: *Dr. A. P. Tormey*, Madison, "Non-Specific Urethritis"; *Dr. Erby Satter*, Madison, "Tryptophane and Bladder Cancer—Preliminary Clinical Report"; Dr. Justin J. Cordonnier, professor of urology at Washington University School of Medicine, St. Louis, Missouri, "Carcinoma of the Bladder" and "Hypertension with Unilateral Renal Artery Disease"; *Dr. N. J. Helland*, Marshfield, "Unilateral Renal Disease with Hypertension"; *Dr. A. P. Schoenenberger*, Madison, "Traumatic Injuries to the Urinary Tract"; *Drs. E. B. Jacobson* and *S. P. Hurwitz*, Milwaukee, "Carcinoma of the Testicle with Retroperitoneal Lymphadenectomy"; *Dr. James W. Sargent*, Milwaukee, "Spontaneous (Non-Traumatic) Renal Hemorrhage—Report of Two

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Cases"; *Dr. John J. Mueller*, Madison, "Necrotizing Renal Papillitis"; and *Drs. Robert S. Irwin*, Milwaukee, *John B. Wear*, Madison, and Justin J. Cordonnier, St. Louis, participated in a Pyelogram Clinic.

The session was held at the Hotel Manitowoc.

THIRD AND TWELFTH DISTRICTS NEWS

Doctor Middleton Receives Degree

Dr. William S. Middleton, former Professor of Medicine and Dean of the University of Wisconsin Medical School, was given an honorary Doctor of Letters degree at Marquette University's Commencement Exercises on June 8.

Doctor Middleton is a native of Norristown, Pennsylvania. He received his medical degree from the University of Pennsylvania in 1911. Following his internship at Philadelphia General Hospital, he became associated with the University of Wisconsin, becoming Dean of the medical school in 1935. In 1954 he was named Chief Medical Director of the Veterans Administration in Washington.

Doctor Angevine Takes Trip

Dr. D. Murray Angevine left May 26 for a trip to the Far East. He is in the department of pathology at the University of Wisconsin and is consultant to the Surgeon General. In this capacity he plans to lecture at military installations in Hawaii, Tokyo, Okinawa and Korea.

Two Madison Doctors Are Board Examiners

A radiologist from Madison, *Dr. Lester W. Paul*, attended the May meetings of the American Board of Radiology in Chicago. While at the sessions he served as examiner for the board.

Dr. Ben Peckham, obstetrician and gynecologist from the University of Wisconsin, acted as associate examiner at the American Board of Obstetrics and Gynecology in Chicago, May 7–17.

Doctor Campbell on Panel

In April *Dr. Ralph Campbell*, Madison obstetrician, was the moderator of two round tables. The panels were given at the American College of Obstetricians and Gynecologists' meeting held in Los Angeles.

Doctor Murphy Retires from County and Marquette Posts

The resignation of *Dr. Francis D. Murphy* as director of medicine at Milwaukee County General Hospital and chairman of the department of medicine at Marquette University was recently an-

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nounced. His duties in these posts will terminate in early fall. Doctor Murphy has stated that he will continue as professor in Marquette's department of medicine and will devote more time to his private practice and medical writing. He had been associated with the hospital since 1926.

Meetings Attended by Doctor Puestow

Dr. K. L. Puestow, a Madison internist, participated in the meetings of the International Society of Internal Medicine in Philadelphia and the annual meeting of the American College of Physicians at Atlantic City. He was also present at the sessions given by the American Society of Internal Medicine.

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Esophageal Surgery, One Week, September 15
Thoracic Surgery, One Week, September 22
Gallbladder Surgery, Three Days, November 3
Surgery of Hernia, Three Days, November 6
General Surgery, Two Weeks, November 10; One Week, October 27
Fractures & Traumatic Surgery, Two Weeks, October 20
Treatment of Varicose Veins, Two Days, September 15
American Board Review Course, Two Weeks, November 10
Blood Vessel Surgery, One Week, October 20

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, Two Weeks, September 8
Vaginal Approach to Pelvic Surgery, One Week, October 6
General & Surgical Obstetrics, Two Weeks, September 22

MEDICINE—General Review Course, Two Weeks, October 20
Electrocardiography, Two Week Basic Course, October 6
Gastroscopy & Gastroenterology, Two Weeks, November 3
American Board Review Course, One Week, September 29, (For Part I Candidates Only)

DERMATOLOGY—Clinical & Didactic Course, Two Weeks, November 3

RADIOLOGY—Diagnostic X-Ray, Two Weeks, September 22
Clinical Uses of Radioisotopes, Two Weeks, September 29

UROLOGY—Two-Week Intensive Course, October 13
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Society Records

New Members

G. E. Whalen, 3014 North Marietta Avenue, Milwaukee.

George Nemec, Greenwood.

T. E. Lynn, 130 East Walnut Street, Green Bay.

Changes of Address

N. P. Anderson, Crystal River, Florida, to 2027 Cass Street, La Crosse.

B. D. Kohne, San Diego, California, to 3128 North 50th Street, Milwaukee.

D. A. Emanuel, Augusta, to 650 South Central Avenue, Marshfield.

J. K. Martins, Eleva, to 206 Fifth Avenue, Eau Claire.

J. P. Walker, Mondovi, to Strum.

A. F. Harter, Rhinelander, to 312 Chander Avenue, Eveleth, Minnesota.

John Hogan, Campbellsville, Kentucky, to Neopit.

W. J. Madden, Milwaukee, to 1841 Wisconsin Avenue, Racine.

B. J. Steves, Menomonie, to Friendship Haven, Fort Dodge, Iowa.

N. H. Schulz, Green Bay, to 185 Stark, Randolph.

A. T. Holbrook, Dunedin, Florida, to 2928 East Kenwood Boulevard, Milwaukee.

J. P. Koehler, St. Petersburg, Florida, to Route 1, West Bend.

R. F. Crockett, Green Bay, to 1509 Draper, Kingsburg, California.

J. W. Goggins, Chilton, to % Al Schumacher, Stockbridge.

E. C. Ferguson, Juneau, to 785 Northeast 198th Street, North Miami, Florida.

W. W. Stebbins, St. Petersburg, Florida, to 126 East Main Street, Madison.

L. J. Enders, ** Milwaukee, to 1710 Sylvan Lane, Montgomery, Alabama.

F. D. Cook, Madison, to 840 South Quincy Street, Green Bay.

J. R. Guy, Barron, to 3309 North Hackett Avenue, Milwaukee.

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News Items and Personals*

Affiliates with Strum Clinic

Dr. J. P. Walker, formerly of Mondovi, has located in Strum as a general practitioner. A graduate of Marquette University School of Medicine, the doctor interned at Milwaukee County Hospital and served three years as an Army medical officer. From 1947 to 1957 he practiced at Mondovi, leaving for a year to serve with the U.S. Air Force. Doctor Walker joined the medical service of the veterans administration in 1957 and was stationed in Texas prior to coming to the Strum Clinic.

New Offices Opened in Wautoma

Dr. L. S. Shemanski, Wautoma, moved in May from his second floor location to a building recently remodeled for offices. The new clinic facilities, to be shared with a dentist, include three examination rooms, combination laboratory and office, drug room, and combination x-ray and emergency room for use by Doctor Shemanski.

* Physicians whose names are printed in italics are members of the Society.

Doctor Anderson Locates in La Crosse

A radiologist, Dr. Edward M. Anderson, recently began practice at La Crosse in association with the Gundersen Clinic and the La Crosse Lutheran Hospital.

Doctor Anderson was graduated in 1935 from the University of Minnesota, practiced in Lamberton, Minnesota, and served in the European theatre during World War II. Upon release from military service, Doctor Anderson took his residency at the University of Minnesota, receiving his certification by the American Board of Radiology in 1949. Prior to his move to La Crosse, he was on the staff of the St. Cloud Hospital in St. Cloud, Minnesota.

Offices Opened in Manitowoc by Dr. Bringe

A dermatologist, *Dr. James W. Bringe,* has opened a part-time office in Manitowoc. Besides his new duty, he maintains an office in Sheboygan, is on the staffs of two Sheboygan hospitals, and is staff consultant at the Plymouth Hospital and at Rocky Knoll Sanitarium.

Burlington Doctor Enters Research

A 1950 graduate of the University of Wisconsin Medical School, *Dr. Leo V. Kempton*, has announced that he will leave his practice in Burlington to enter the space research field. He has been associated with the Burlington Clinic since 1952.

Honorary Degree Presented to Wilder Graves Penfield

Wilder Graves Penfield, universally recognized as the most eminent brain surgeon of our time, was given an honorary degree of Doctor of Science at the University of Wisconsin Commencement Exercises held recently.

Doctor Penfield is a child of Wisconsin parents and grew to manhood in this state. He received his medical degree at the Johns Hopkins University.

Dr. E. P. Schuh Is Guest Speaker

A talk entitled, "Hypertension", was given by *Dr. E. P. Schuh* to the St. Mary's Hospital Auxiliary May meeting in Watertown. The lecture, which was augmented with a film on the circulation of the blood, explained conditions causing abnormal pressure and flow changes. Doctor Schuh's presentation was followed by a question and answer period.

Doctor Taugher Honored

Dr. V. J. Taugher of Berlin has recently been elected as an honorary member of the British Society of Medical Hypnotists.

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Neenah Physician Retires

A half-century of medical service to the residents of Neenah and Menasha ended June 1 when *Dr. T. D. Smith* retired. By the time Doctor Smith reaches the age of 74, on September 1, he expects to be settled in Woodland Hills, an area north of Beverly Hills, California. One of his physician sons, Robin, resides north of Hollywood. The other son is an obstetrician in Phoenix.

Dr. T. D. Smith

He came to Neenah in 1911 after serving his first year of practice in Weed, California. His medical career began with preparatory education at Casenovia Seminary in New York, the state in which he was born. He received his medical degree in 1908 from Syracuse University. He interned at St. Luke's hospital in Utica.

Doctor Smith served in the medical corps during World War I and was the first American officer to be wounded in Europe. He was a ranking medical officer of the Wisconsin State Guard in World War II and is one of 70 men in the country selected by the Secretary of Defense for the National Defense Orientation Committee.

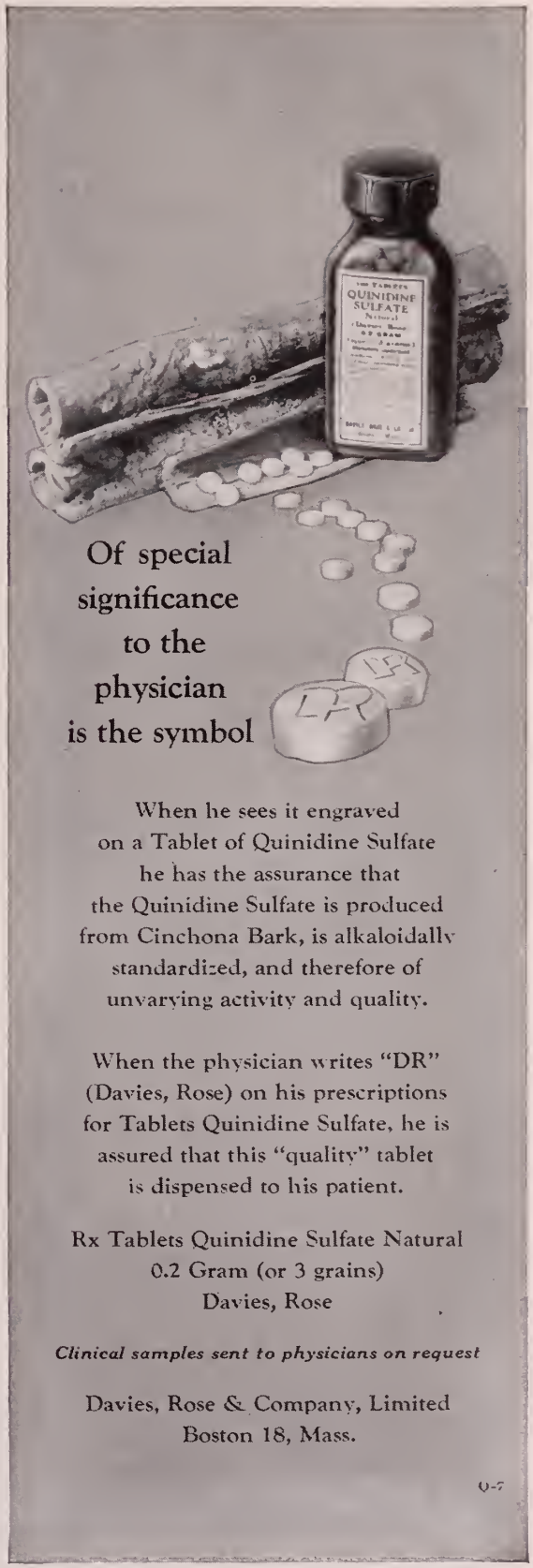
In disposing of his assets in Neenah, Doctor Smith has written the following note to his city assessor who looks forward each year to his annual plea:

"I have given my entire office equipment, furniture, x-ray, microscope, sterilizer, instrument cabinets and all surgical instruments to a medical mission in Burma.

"As of June 1, 1958, I will have no personal property except for one old automobile and the clothes on my back. Please be accordingly lenient with me come January 1."

Dr. Leo Furr Affiliates with River Falls Clinic

Dr. Leo Furr joined the staff of the River Falls Clinic in April. He graduated from St. Louis University School of Medicine in 1953, interned at St. Joseph's Hospital in St. Paul, Minnesota, and then practiced for a short time at Bird Island, Minnesota. Doctor Furr served two years with the United States Air Force, from 1955 to 1957, and came to River Falls from a surgical residency at St. Joseph's Hospital in St. Paul.



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Advertisements for this column must be received by the 15th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from individual members of the State Medical Society will be accepted without charge. The charge quoted previously applies to advertisements placed by clinics. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.

INTERN DESIRED: Associate wanted in Central Wisconsin community of about 13,000. Address replies to Box 731 in care of the Journal.

PHYSICIANS, with or without pediatric training, needed in maternal and child health program at salaries ranging from $8,728 to $10,765. Five-day week, pension, civil service appointment. Address replies to Dr. E. R. Krumbiegel, Milwaukee Health Department, City Hall, Milwaukee, Wis.

GENERAL PRACTITIONER AVAILABLE for locum tenens from Dec. 1, 1958, to Jan. 1, 1959, when I start orthopaedic residency. Have had some training in surgery and orthopaedics. Prefer Madison area or southern Wisconsin. Now stationed in Japan with Air Force. Have license to practice in Wisconsin. Address replies to Box 738 in care of the Journal. p7–8

MEDICAL AND SURGICAL GROUP would like to form association with young doctor interested in one, two, or three year appointment as assistant in surgery, and to assist in the handling of emergency and industrial cases. Contact Box 736, in care of the Journal. 7–9

WANTED: General practitioner immediately to rent a general practice, fully equipped office with option to buy. Excellent opportunity for a secure, fast start. Call Fulton 6–4901, Juneau, Wis. m7–8

WANTED: Physicians interested in general and specialty practice are urgently needed in Watertown, Wisconsin, due to several physicians leaving for specialty training. Town 15,000 population. Hospital privileges available. Will give assistance in obtaining office space. Information available by contacting: Chief of Staff, St. Mary's Hospital, Watertown, Wisconsin.

WANTED—OBSTETRICIAN AND GYNECOLOGIST, with emphasis on gynecology, to associate with general practitioner in city of approximately 14,000, in southeastern Wisconsin. Large surrounding trade area. 83-bed hospital. Modern, well-equipped office, above pharmacy. Contact Box 732, care of Journal. m6–7

EXCELLENT OPPORTUNITY FOR GENERAL PRACTITIONER or internist at Watertown. 83-bed hospital. Large trade area. Excellent schools, most denominations of churches, one hour's drive to Milwaukee or Madison. Contact Box 733, care of the Journal. m6–7

WANTED TO PURCHASE—A used Ritter motorized proctologic table or comparable unit in good condition. Write Post Office Box 487, Sheboygan, Wisconsin. m6–7

LOCUM TENENS AVAILABLE: Wisconsin licensed physician available for one month during May. June or July to do general practice. Will need few day's notice. Now at University Hospitals, Madison. Address replies to Box 727 in care of the Journal.

LOCUM TENENS WANTED from July 23rd to Aug. 6, residence and car available. Please write to Harold J. Werbel, M.D., Delavan, Wisconsin. m6

WANTED: General practitioner in eastern Wisconsin city of 4,000, plus drawing population 5,000; 2 hospitals within 6 miles; industrial community; heavy rural population; office space available. Contact Box 740 in care of the Journal. p7–8

LOCUM TENENS: Resident in surgery desires locum tenens for two months (July and August) to do general practice and surgery. Contact Theodore S. Roberts, M.D., University of Wisconsin General Hospital, Madison, Wisconsin.

WANTED: Young, white, male M.D. for surgical assistant and also general practice in 16 man medical group. This is a one or two year appointment beginning July 1, 1958, and is a good opportunity to obtain training under qualified men. Write giving resume and salary expected to Midelfart Clinic, Eau Claire, Wisconsin.

OFFICE AVAILABLE IN MEDICAL ARTS BUILDING: A modern medical office for private practice is available for immediate occupancy, in an established MEDICAL ARTS BUILDING. Located in a northern Wisconsin city of 10,500, and includes an area of 30,000 people, two fully accredited hospitals. Excellent opportunity. Address replies to Box 725 in care of the Journal.

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FOR SALE—Medcosonlator machine, a combination of ultra sound with the Medcolator which is a muscle stimulating device. 1956 model used very little. Contact C. W. Docter, M.D., 610 Sixth Street, Racine, Wis.

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FOR SALE: Deceased physician's equipment—Fischer x-ray machine (looks like new), developing tank, casettes, sterilizer, microscope, centrifuge, examining table, some furniture, books, etc. Contact Box 739 in care of the Journal. 7–8

E.N.T. man available for part or full time association with small group in and around the Milwaukee area. Contact Box 734, care of the Journal. m6–7

RADIOLOGIST: Desires new Wisconsin location in clinic group or hospital, age 33, diploma American College of Radiology, isotope licensed. Address replies to Box 735, care of Journal. m6–7

HOST TO WISCONSIN–UPPER MICHIGAN SOCIETY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY

The Eye and Ear, Nose and Throat Departments of the University of Wisconsin Medical School were hosts to the members of the Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology at a meeting held at the University in Madison on May 24 and 25, 1958.

An intensive course was presented dealing with recent advances in surgical techniques in cataract extraction after filtering surgery, corneal transplant, scleral buckling, plastic surgery of the eyelids, and primary neoplasms of the sphenoid sinuses. New concepts of diabetic vascular disease were discussed by a guest speaker, and demonstrations were presented by each of the participating departments.

The program included the following:

"Primary Neoplasms of the Sphenoid Sinuses" by Paul Radlet, M.D., and Maxine Bennett, M.D.

"Scleral Buckling Operation", movie, by Matthew D. Davis, M.D.

"Cataract Extraction and Filtering Surgery" by Peter A. Duehr, M.D.

"Diabetic Vascular Disease" by Edgar S. Gordon, M.D.

"Mexico" (illustrated with colored slides) by Maxine Bennett, M.D., and Margaret Prouty, M.D.

"Trauma to the Larynx" (a case report) by R. D. Lange, M.D.

"Chelating Agent in Otosclerosis" by Mr. Raymond Stecker.

"Experiences with Corneal Transplant" by John V. Berger, M.D.

"Plastic Procedures of the Lids" by Frederick J. Davis, M.D.

E. N. T. Demonstration by C. R. Taborsky, M.D.

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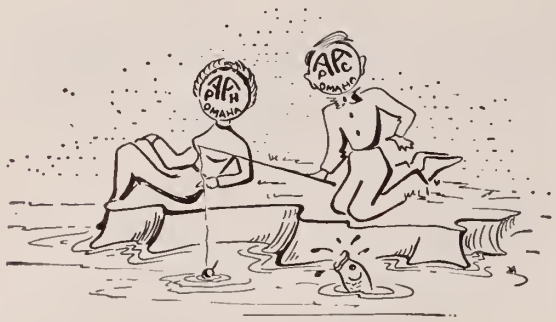

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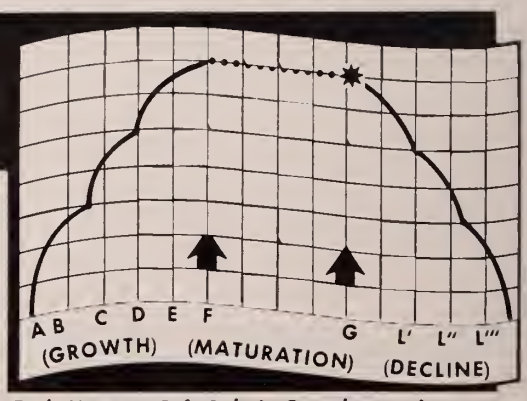

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*Chappel, C.C., J.A.M.A., 162: 1414, (Dec. 8) 1956

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Association of Wisconsin Psychiatric Clinics for Children

A program emphasizing clinical problems was presented at the semi-annual meeting of the Association of Wisconsin Psychiatric Clinics for Children held June 13 and 14 at Hotel Eau Claire, Eau Claire. The group, composed of representatives of 18 Child Guidance Clinic staffs in Wisconsin, numbered 60, and included members of the three basic professional disciplines in psychiatric clinic teams: psychiatrists, psychiatric social workers and psychologists.

The clinical part of the program at this meeting emphasized projects and approaches within Wisconsin itself. Dr. Harold Borenz, Assistant Professor and Head of Department of Child Psychiatry at University of Wisconsin Medical School, presented a paper describing a new approach to the treatment of psychotic children. Dr. Leland Reeck, President of the Association, and Psychiatric Director of the Dane County Child Guidance Clinic, discussed a project in Family Life Education. Another major focus was on Group Therapy for Married Couples, presented by Mr. Edward Burdulis, psychologist at Dane County Child Guidance Clinic. These topics were amplified in general "Workshops," comprehensive discussions by the entire assemblage. The host group, the Eau Claire Guidance Clinic, provided a tour of their Clinic facility and also presented a demonstration of a public education technique.

Among other problems discussed were a recommendation to the State Legislature regarding residential treatment centers and other possible youth programs, relationships between the clinics and the two State agencies dealing with related problems (the State Department of Public Welfare and the State Board of Health.)

The Association was formally organized in 1956 by representatives of the staffs of several Wisconsin Guidance Clinics. The intended goals include coordinating the activities of Child Psychiatric Clinics

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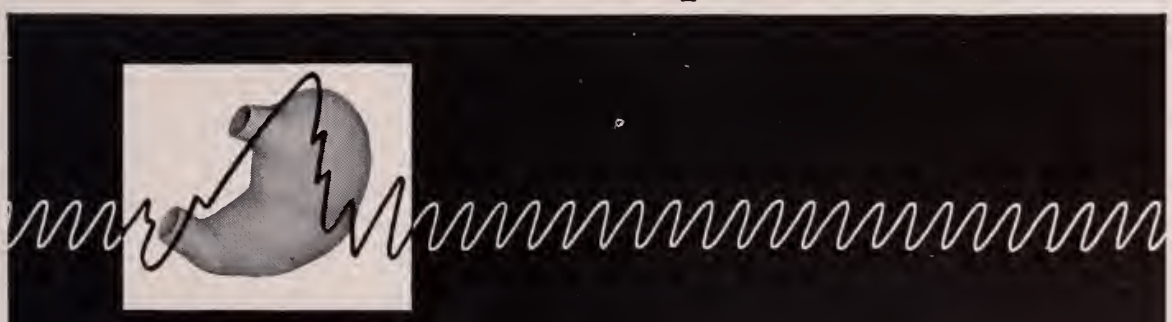

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in Wisconsin, helping to maintain the highest possible standards of clinic practice, providing opportunities for the exchange of ideas and for the mutual help in the study and solution of clinic problems, promoting the training of clinic personnel, and cooperating with appropriate organizations whose purposes overlap with those of the Wisconsin clinics.

As noted by the Association the problem of emotional illness in children has steadily but inevitably come to the forefront in modern day living; its ravages have significantly and oftimes severely affected numerous segments of present-day society throughout the world. In Wisconsin, as elsewhere, these groups frequently turn for assistance, advice and collaboration to the clinical specialists in the evaluation and treatment of childhood disturbances. As the Clinics have come to fill this role in the local communities it is expected that the Association will become a state-wide spokesman and clearing house for a similar function. As a consequence, the Association has already established communication with such public service agents as legislators, lawyers, judges, police, physicians, teachers, and welfare workers.

The member clinics of the Association include: Brown County, Green Bay; Dane County, Madison; Dodge County, Juneau; Douglas County Center, Superior; Eau Claire County, Eau Claire; Fond du Lac County, Fond du Lac; Jefferson County, Jefferson; Kenosha County, Kenosha; La Crosse County, La Crosse; Manitowoc County, Manitowoc; Milwaukee County, Milwaukee; Racine County, Racine; Rock County, Janesville; Sheboygan County, Sheboygan; Washington–Ozaukee County, West Bend; Waukesha County, Waukesha; Wisconsin Diagnostic Center, Madison; University Hospitals, Madison.

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THE WISCONSIN MEDICAL JOURNAL

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Gallstone Ileus

Seven Cases With Two Recurrences *

By THOMAS J. FOLEY, M. D.**, and JACK SELZER, M. D.***

Milwaukee

EVERY busy surgeon will see a patient with gallstone ileus sooner or later during his career. The patient will probably be an elderly female in critical condition. About one-half of these patients will have an antecedent history of gallbladder disease. Early diagnosis and a knowledge of the therapy used in similar cases will greatly increase the patient's chances of survival. For this reason we should like to present our experiences with gallstone ileus in seven patients who were admitted to Milwaukee County General Hospital between 1940 and 1950.

Case 1: A 68-year-old white woman entered the hospital complaining of abdominal colic, obstipation, and vomiting of four days' duration. Shortly before admission she vomited fecal-like material. The patient was a diabetic. She had also noted an intolerance to fatty food for several years before admission. Physical examination revealed a slightly distended and tender abdomen. A roentgenogram demonstrated an obstruction of the small bowel. Two days after admission an exploratory laparotomy was performed. A gallstone, 3 cm. in diameter, was found impacted in the terminal ileum. The calculus was removed by simple enterotomy. The patient's postoperative course was complicated by a wound infection. She was discharged 34 days after admission.

Case 2: A 64-year-old white woman had an initial complaint of abdominal colic and persistent vomiting which later became fecal in character. She had not had a bowel movement for four days before admission. She was critically ill and dehydrated. Her abdomen was slightly distended. A roentgenogram of her abdomen disclosed a small bowel obstruction. Two days after admission an exploratory laparotomy was performed. A gallstone, 3 cm. in diameter, was removed from the terminal ileum. Her postoperative course was complicated by congestive heart failure. She was discharged 12 days after admission.

Case 3: *First Admission*—The patient, a 65-year-old white woman, was admitted to the hospital because of abdominal colic of 10 days duration and fecal-like vomiting. Diarrhea occurred shortly after the onset of her symptoms. However, her bowel movements ceased several days before admission. Physical examination revealed a tender mass in the right lower quadrant of her abdomen and moderate abdominal distention. Roentgen examination demonstrated a small bowel obstruction. A radiopaque liquid substance was seen within the distended loops of small bowel. Four days after admission an abdominal operation was performed. A gallstone, 2.5 cm. in diameter, was found impacted in the terminal ileum. There was also an abscess at the point of the obstruction. The calculus was removed from the ileum and the abscess was drained. Following the operation a repeat roentgenogram showed a collection of air which was considered to have the configuration of the biliary tree. Atelectasis and persistent drainage from the wound marred her postoperative course. She was discharged 24 days after admission.

Second Admission (Ten Months Later)—The patient re-entered the hospital because of intermittent abdominal pain and persistent

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vomiting. Her abdomen was slightly distended. Upright and supine roentgenograms were suggestive of an ileus, and a calcific density, 1 cm. in diameter, was demonstrated in the right upper quadrant of her abdomen. The treatment was conservative, consisting of intestinal suction and intravenous fluids. Four days after admission a repeat roentgenogram showed an obstruction of the small bowel. An exploratory laparotomy disclosed a gallstone impacted in the lower portion of the ileum. Except for a wound infection the patient did very well. She was discharged on the thirtieth postoperative day.

Case 4: A 69-year-old white woman gave a history of abdominal colic, vomiting, and obstipation of 10 days duration. She had had symptoms in the past suggestive of gallbladder disease. On admission her abdomen was slightly distended and tender. A roentgen examination demonstrated a calculus in the region of the gallbladder and a radiopaque liquid material within the splenic flexure and transverse colon. A repeat roentgenogram four days later showed the calculus in the right lower quadrant of the abdomen and a collection of gas within the biliary tree. Distended loops of small bowel were also noted. The appearance of these distended loops was consistent with the diagnosis of obstruction of the small intestine. At operation two gallstones, measuring 3 cm. and 2.8 cm. in diameter, were found in the terminal jejunum and also in the region of the ileocecal valve. The patient expired during the operation.

Case 5: The patient, a 74-year-old white woman, entered the hospital because of intermittent abdominal colic of 14 days duration and fecal-like vomiting. She had had similar abdominal pain seven months before admission. On admission she was critically ill. The roentgenograms demonstrated complete obstruction of the small bowel. Two days after admission a gallstone, 3.5 cm. in diameter, was removed from the jejunum. During the operation a mass, which was thought to contain calculi, was felt in the right upper quadrant of her abdomen. After the operation the original roentgenograms were reviewed and calculi were seen in the region of the gallbladder and in the small bowel. On the eleventh postoperative day an obstruction of the small bowel again developed. A repeat exploratory laparotomy disclosed another calculus impacted in the jejunum. The calculus was removed by enterotomy. There were no other gallstones within the gallbladder. The patient recovered slowly and was discharged three months after admission.

Case 6: A 62-year-old white woman had an initial complaint of intermittent abdominal pain for three days before admission. There was also a history of obstipation and fecal-like vomiting. Previous symptoms were suggestive of gallbladder disease. On physical examination the roentgen findings were consistent with ileus. Also, air was seen within the biliary tree. The roentgenology department made the diagnosis of gallstone ileus. However, an operation was not performed as the patient appeared to be improving. Four days after admission she passed a 5 by 2.5 cm. gallstone from her anus. She was discharged nine days after admission.

Case 7: An 80-year-old white woman entered the hospital because of severe pain in the right upper quadrant of her abdomen which was accompanied by nausea and vomiting. Shortly before admission the pain moved into the left lower quadrant. Her history was consistent with a diagnosis of chronic cholecystitis and cholelithiasis. Physical examination disclosed a markedly tender mass in the left lower quadrant of her abdomen. There was also referred and rebound tenderness to this region. An upright and supine roentgenogram of the abdomen disclosed several distended loops of small bowel. At the time of operation a calculus was found impacted in the jejunum two feet distal to the ligament of treitz. Twelve inches of the jejunum proximal to the gallstone were gangrenous and had to be excised. An end-to-end jejunojejunostomy was performed. The patient was discharged from the hospital nine days after admission. She died 19 months later of adenocarcinoma of the gallbladder.

DISCUSSION

The diagnosis of gallstone ileus is very difficult. There is no specific sign, symptom, or roentgen finding that points directly to the diagnosis of the disease. However, there are signposts which occassionally guide the surgeon along a devious path to the proper diagnosis.

An understanding of the pathogenesis of the disease is paramount in establishing a diagnosis. Two important pathologic conditions are invariably present within the patient before an obstruction due to gallstones

can occur. The first condition is cholelithiasis. The second pathologic condition is the presence of an abnormal communication between the biliary passages and the intestinal tract. This abnormal communication occurs following an exacerbation of acute cholecystitis in a chronically diseased gallbladder. Most observers believe that a gallstone large enough to obstruct the small intestine must pass from the gallbladder into the intestine by an abnormal route. That is to say, that such a gallstone would be too large to pass through the ampulla of Vater.[1 4] Dietary fat can be combined with bile acids in the intestinal tract forming concretions superficially resembling gallstones. Each stone must, therefore, be carefully examined in order to insure an accurate diagnosis of gallstone ileus. Gallstones may remain within the intestinal tract for long periods of time. Some patients will not have symptoms. Other patients will have symptoms compatible with those of an intermittent obstruction of the small intestine. Some may pass the stones per anus (Case 6).[5,6] Finally, in others a complete obstruction of the small intestine will develop with all of its associated pathophysiologic sequelae. At the same time the obstruction occurs, localized damage may take place within the lumen of the intestine due to the presence of the impacted gallstone. These changes are vascular impairments, pressure necrosis, localized peritonitis with abscess formation, (Case 3),[7] and even free perforation with a resulting generalized peritonitis.

A thorough history and physical examination is always necessary to establish the diagnosis in the acute surgical abdomen. In gallstone ileus the signs and symptoms are primarily those of an obstruction somewhere within the gastrointestinal tract. All of our patients had abdominal colic, usually of long duration, and in the majority of the patients the pain tended to shift from one region of the abdomen to the other.[2] All of the patients were dehydrated, and all of them exhibited some degree of abdominal tenderness and distention. Five of the patients had fecal-like vomiting before admission. Five of the patients had not had a bowel movement for from two to ten days before admission; and, finally, five of the patients gave a history of gallbladder disease.

The roentgen findings are also of great diagnostic value. Doctor Rigler points out four roentgen manifestations of gallstone ileus:[3] (1) Air or contrast media in the biliary tree. (2) Direct visualization of stones or indirect visualization of stones by means of contrast media in the intestinal tract. (3) Change in position of a previously observed stone. (4) Roentgen evidence of partial or complete intestinal obstruction.

Of course, all of these roentgen findings are not always present. In fact, two of the above roentgen manifestations would probably be sufficient to make the diagnosis of gallstone ileus. In our series of cases air was demonstrated within the biliary tree on only three occasions. (Cases 3, 4 and 6). In one of these cases (Case 3) the air was not seen until after surgery; that is, after the diagnosis of gallstone ileus had been established. Gallstones were demonstrated roentgenographically in only two cases (Cases 4 and 5). Here, again, the stones were not seen until after surgery when the films were reviewed. In Althaus' patient x-ray identification of the stone led to the correct preoperative diagnosis.[8] Barium enema and barium meals were not used routinely in our series of cases. In two of the cases (Cases 3 and 4) a radiopaque liquid material, "milk of calcium" or "limy bile," was demonstrated on the abdominal roentgenograms.[9,10] A heavy lime salt content renders bile visible. However, "limy bile" is seen only rarely. It is doubtful whether this material is of any significance in the roentgen diagnosis of gallstone ileus. Finally, in all of the cases the roentgen findings were compatible with an obstruction of the small intestine.

TREATMENT

Every physician realizes the dangers of being dogmatic about treatment. Treatment must be tailored to fit the specific patient. This is also true of gallstone ileus. However, treatment can be simplified if we keep certain points in mind. (1) The patients are usually over 60 years old and are markedly dehydrated. (2) Complete obstruction of the small intestine can rarely be relieved by conservative therapy. (3) The longer complete obstruction of the intestine is present, the greater are the chances of serious sequelae and the higher is the mortality rate. (4) There is a high rate of recurrence.

With the above four points in mind the patient should be prepared for an exploratory laparotomy as soon as possible by means of

intravenous fluids, whole blood, and intestinal intubation. The operative procedure should be as simple as possible. The gallstone in the gastrointestinal tract is located by gentle palpation and removed by simple enterotomy. It is preferable to do the enterotomy in apparently normal bowel adjacent to the gallstone. The remainder of the large and small bowel are also explored because of the possibility of other calculi within the gastrointestinal tract. Finally, the region of the gallbladder is carefully palpated. If calculi are felt within the gallbladder, they are removed by cholecystotomy and the gallbladder is drained. This is a controversial point. However, we feel that the high recurrence rate in gallstone ileus makes cholecystotomy mandatory when other large calculi are found within the gallbladder. No attempt is made to correct the cholecystoenteric fistula. This method of therapy was performed on three subsequent patients with excellent results. These patients will be presented in another paper when their follow-up studies have been completed.

Ten to 12 days after the operation a cholangiogram should be performed through the cholecystostomy tube. If no calculi are seen the tube is removed. Because of the patient's age and condition no further operative procedures are indicated, and probably no further operative procedures will be necessary.

CONCLUSIONS

The preoperative diagnosis of gallstone ileus is difficult. We must use every tool at our disposal to make the diagnosis; for early diagnosis is the key to successful treatment.

The treatment of gallstone ileus can be divided into two parts: (1) Alleviation of the obstruction within the gastrointestinal tract as quickly as possible and with the least amount of trauma; (2) The performance of a cholecystotomy if large calculi are palpated within the gallbladder at the time of operation.

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Obstetrical Brief

From the Study Committee of the Maternal Mortality Survey, Division on Maternal and Child Welfare, State Medical Society of Wisconsin

Shock and Surgical Intervention in Ruptured Ectopic Pregnancy

Death occasionally results from slavish adherence to rules of thumb. The dictum that shock contraindicates surgical intervention in ruptured ectopic pregnancy is a useful concept if not taken too literally. Occasionally, however, blood pressure cannot be maintained until the ruptured arteries are ligated. In such instances prolonged attempts to restore blood pressure may lead to irreversible shock and death. It should be emphasized that the great majority of patients with hemoperitoneum due to this condition will respond to adequate and rapid blood replacement under pressure through multiple ports and large caliber needles or cannulas. The single bottle run at a slow drip has no place in such circumstances. Plasma and plasma expanders can only be temporarily useful.

A better rule would seem to be: shock should be controlled *wherever possible* prior to surgical treatment of ruptured ectopic pregnancy.—BEN PECKHAM, M.D.

International College of Surgeons

Montana Surgical Section Meeting, Billings, September 10. For information, write to Louis W. Allard, M.D., 1231 N. 29th St., Billings, regent of Montana.

Tennessee Surgical Section Meeting, Chattanooga, September 29. For information, write to William G. Stephenson, M.D., 612 Medical Arts Building, Chattanooga 3, regent of Tennessee.

The Value of the Papanicolau Smear in the Diagnosis of Carcinoma of the Uterine Cervix and of the Uterine Fundus*

By A. D. ANDERSON, M. D., and G. G. KRING, M. D.

Madison

SINCE the inception of surgical treatment for carcinoma, early diagnosis and treatment have been the goal of every surgeon in an effort to increase the surgical cures. G. N. Papanicolau[1] in 1933 found that malignancies could be diagnosed by individual cells or by groups of cells exfoliated from their surfaces. This test, which we call the "pap smear", is now widely used in the diagnosis of cancer of the lung, urinary bladder, esophagus, stomach, breast and uterus.

This paper is presented to indicate the value of this test in a small clinic practice for the diagnosis of cancer of the uterine cervix and fundus. Our primary aim is to diagnose the disease at a very early stage; that is, prior to invasion and to the appearance of any symptoms, and at a stage whereby surgical removal offers an excellent chance of complete cure.

We began using this test extensively in 1953 in our clinic. Routine smears were taken on nearly all of the women seen in our offices for general physical examination. During its early use, an accurate record of the total number was not kept; however, since November, 1955, we have done 1,043 Papanicolau smears. We estimate 300 individual tests prior to November, 1955, for a total of 1,343 procedures. Some of the later tests have been repeat smears on women who have had others done previously. We advise repeat smears to be taken at least once each year. On those patients who have had negative smears and subsequently show a positive smear, it should indicate an early curable lesion.

TECHNIQUE

All patients were instructed not to douche and not to use contraceptive jellies during the two days preceding the test. If at the time of the original history and examination these requirements were met, the test was taken. If not, the patients were instructed and asked to return. Tap water only, used as a lubricant, was sprinkled on the gloves and on the speculum. After careful external examination of the vulva, the speculum was inserted and the test was taken immediately. The aspirator present in all Papanicolau kits was used first. The aspirator was inserted directly into the cervical os and all free fluid and mucous was obtained. If insufficient material was present in the cervical os, the posterior cul de sac was also aspirated and smeared to make the first slide. The second slide was prepared by using half a tongue blade which was split lengthwise. The apex of the tongue blade was inserted into the cervical os; and with the os as a pivot point, the tongue blade was scraped against the mucocutaneous junction of the cervix, hard enough in most cases to cause some bleeding. This generally produced enough material for a very good slide. Immediately upon smearing, the slides were dropped into a bottle containing 95 per cent alcohol. The kit was then sealed and sent to the State Laboratory of Hygiene for interpretation.

RESULTS

From the 1,343 total tests done, we have found 21 carcinomas of the cervix and four carcinomas of the uterine fundus exclusively by the Papanicolau smear. Two carcinomas of the fundus and six carcinomas of the cervix were found by other means during this time. A total of 33 cases of uterine cancer was found.

* Presented at meeting of the Wisconsin Surgical Society, Madison, September 21, 1957.

We would like to take this opportunity to publicly thank Doctor Stovall and all of the personnel at the State Laboratory of Hygiene, and also Doctor McGary and Doctor Piper and their staff in our laboratory at Madison General Hospital for their help in the interpretation of the Papanicolau smears and the surgical specimens that we have presented to them.

Table I—Results of Smears

	Diagnosis by Papanicolau Smear		Diagnosis Missed by Papanicolau Smear		Total Smears	Per Cent Positive	Per Cent Accuracy
	Cervix	Fundus	Cervix	Fundus			
Stage 0	11						
Stage I	8						
Stage II	2						
Total	21	4	3	1	1343	1.8%	86%

The diagnosis was verified by a surgical procedure in each of the 25 cases found by the Papanicolau smear. It should be emphasized at this time that the smear alone should not be relied upon, but indicates the need for further study. Of the 21 cervical cancers, the lesion was found to be localized to the superficial layers (in situ, *stage 0*) in 11 cases. The remaining 10 cervical lesions were already invasive, eight being *stage I*, and two were *stage II*. Of the four fundal carcinomas found two had no evidence of myometrial invasion. The third case demonstrated superficial invasion. The fourth case was very unusual because two repeat smears were positive for malignant glandular cells, and a dilatation and curettage failed to verify the diagnosis. Total abdominal hysterectomy was done, and a tiny focus of adenocarcinoma was found in the myometrial glands. I have heard of a case with a similar sequence of events where the lesion was found in one of the Fallopian tubes. In four of the remaining cases of uterine cancer, the diagnosis was made without taking Papanicolau smears. The diagnosis was obvious in three of these cases because of far-advanced lesions with post-menopausal bleeding. The fourth patient was a 29-year-old habitual aborter who was bleeding when she was seen in the office. Dilatation and curettage and cervical biopsy were advised in an attempt to find the cause of the repeated abortions. Her lesion was in situ of the cervix.

One very early carcinoma of the fundus and three of the cervix were found in spite of a negative Papanicolau smear. Two of the cervical lesions were in situ as proven by dilatation and curettage and a biopsy of the cervix. The third lesion was a late *stage I*. This gives us a figure of 86 per cent accuracy of diagnosis in the 29 cases of carcinoma of the uterus in which a Papanicolau smear was done. It also indicates that smears that were positive for malignant cells led to a positive diagnosis of carcinoma in 1.8 per cent of the 1,343 women seen and tested in our offices. Two of the 21 cases of cervical cancer occurred in women who had had a previous subtotal hysterectomy. In reviewing these cases we made an interesting observation which I feel justifies reporting. Trichomonas organisms were noted on the slides by the pathologist in about one-third of the cancer cases, and in several others that were reported as having atypical cells but were proved not to be malignant.

SYMPTOMS AND SIGNS

We were both impressed by the fact that in seven of these patients with cervical cancer, no symptoms or signs relative to the pelvis were present. Furthermore, in 15 of the 21 cases of cervical cancer, the presenting symptoms were in some other system.

Table II—Symptoms and Signs

	None	Discharge	Bleeding	Erosion
Cervix	7	7	3	8
Fundus	0	1	3	0

Pelvic symptoms were present in 14 of the 21 cases. A vaginal discharge was noted in 10 cases. The discharge was bloody in three cases, and was white to purulent in seven cases. Only eight could be described as having a visible cervical lesion or an erosion. Bleeding was the presenting symptom in three of the four fundal lesions. A profuse vaginal discharge was noted by the fourth patient.

AGE

In the past, it was the opinion of surgeons and of gynecologists that cancer of the cervix was a disease of elderly women. Our experience with this series of cases has convinced us otherwise. Six of the 21 cases of cervical cancer were in women less than 40 years old; 11 were less than 45 years old; the youngest was 30 years old; and the oldest

was 74 years old. Of all of the 11 patients with in situ lesions, the average age was only 42 years. The age of the patients with *stage I* lesions averaged 56 years, and those with *stage II* lesions averaged 61 years. The four patients with carcinoma of the fundus ranged from 48 years to 75 years and averaged 60 years. These figures, although not statistically valid, do show a definite trend.

TABLE III—AGE

	Cervix	Fundus
Age Range	30–74	48–75
Average Age	49	60

TABLE IV—AGE, CARCINOMA OF THE CERVIX

	Stage		
	0	1	2
Age Range	30–57	34–74	53–70
Average Age	42	56	61

TREATMENT AND RESULTS

At the present time we have a fixed routine to verify the diagnosis of all cases that return with a positive Papanicolau smear, regardless of whether the cells are epidermoid or glandular. The patient is hospitalized and a dilatation and curettage and a cold knife conization of the cervix is done the following day. A moist sponge is packed into the cervix and is left in place for 24 hours to prevent bleeding. Cautery is not used because of the marked increase in the inflammation around the cervix which occurs. The pathologist is able to give us a report the day after surgery, unless a very tiny lesion is present and serial sections are necessary to find it. If the cancer is *stage 0*, it is our opinion that total abdominal hysterectomy is the treatment of choice. In our series, total abdominal hysterectomy was done on several early *stage I* lesions. These were cases in which the biopsy report came back as in situ; but when the entire specimen was removed, a small focus of invasion was found. The ovaries are left in place if the patient is not menopausal and is less than 45 years old. The tubes, a wide area of the ligaments allowing only enough tissue for an adequate ligation inside the ureter, and at least a one-inch cuff of vaginal mucosa is removed. If the lesion is *stage I*, by biopsy, or is more advanced, we feel that irradiation is the treatment of choice.

TABLE V—TREATMENT AND RESULTS

	Surgery Only	Irradiation and Surgery	Irradiation Only	Total	Living Without Known Metastases
Cervix	16	3	2	21	20
Fundus	2	2	0	4	4

At the present time fundal lesions are treated with radium followed in three to six weeks by total abdominal hysterectomy and bilateral salpingo-oophorectomy.

Total abdominal hysterectomy was done for 18 of the 21 cases of cervical carcinoma. In three, the surgery followed irradiation by five to six weeks. Surgical excision of the cervix only was done for one, and irradiation only was the treatment for two cases. The case of the surgical excision of the cervix was a late *stage I*, and irradiation would now be the treatment of choice.

Intrauterine radium was used in two of the four cases of fundal carcinoma, followed in three weeks by hysterectomy in one case and in six weeks in the other.

All but two of these cases have been followed at regular intervals. With the exception of one case with a *stage II* lesion and known metastases, all are alive and are clinically well.

SUMMARY AND CONCLUSIONS

During a three-year, eight-month period, an estimated 1,343 Papanicolau smears were made. Twenty-one malignant lesions of the cervix and four lesions of the fundus were diagnosed entirely by the Papanicolau smear.

One carcinoma of the fundus and three of the cervix were diagnosed in spite of negative Papanicolau smears. These figures give us approximately 86 per cent accuracy.

The Papanicolau smear is a simple test and should be used routinely on all adult women that enter our offices. It is especially useful as a means of following patients who have received irradiation for cervical cancer, and it should be used during pregnancy.

Patients with carcinoma of the cervix do not necessarily have symptoms or a visible lesion.

Trichomonas infections of the cervix and of the vagina should be treated vigorously and cleared up as quickly as possible.

Early carcinoma of the cervix is a disease of young women, and when found at this early stage can be treated surgically with an excellent chance of cure.

---

2 West Gorham Street.

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Constipation Related to Sudden Death by Blood Clot, Researcher Reports

Vascular accidents and quick death may result from excessive bathroom straining, Dr. David Selman, Department of Experimental Therapy, Stuyvesant Polyclinic Hospital, N. Y., told the 4th Annual Meeting of The American College of Angiology June 22 at San Francisco.

At present the only corrective approach is the reduction of straining through the administration of the constipation corrective Senokot, said Dr. Selman. This effectively and simply reduced the incidence of high and excessive straining, thereby favorably modifying these critical responses of the peripheral vascular system.

On the basis of hundreds of patient observations, he reported that certain of the changes caused by straining are of sufficient intensity and duration to bring on an automatic cycle of extreme variations in blood pressure and circulation—known as the Valsalvo maneuver.

The Valsalva maneuver is a phenomenon which occurs during straining when the air pressure in the chest cavity is forcibly raised to an abnormal degree of at least 40 mm. of mercury and sustained for eight to ten seconds. Under these conditions, there results in sequence a series of reflex circulatory changes including sharply rising and falling arterial and venous blood pressures, delayed circulation time, pulse rate change, and alteration of the electrocardiogram in certain individuals whose cardiovascular status is presumably normal.

The study which directly measured the changes in venous pressure and the arterial circulation in the extremities during actual bowel function of normal and constipated males and females showed that straining initiated marked elevations. These changes further increased with the severity of the straining.

The venous pressure increaed dramatically during the strain period, as high as 40 to 50 millimeters over the resting period and abruptly dropped to the base level with the sudden release of the strain. This action, Dr. Selman noted, "is capable of causing a suction action which is capable of detaching a bland thrombus and could cause sudden death if the blood clot became lodged in the lungs or heart." He further disclosed, "that from 50 to 60 percent of all normal adults of middle age or over harbor silent detachable clots (clots producing no symptoms) in the veins of their feet or calves."

A similar but opposite set of circulatory variations were observed in the arterial circulation during straining associated with bowel functioning, while the venous pressure increased, the blood flow in the peripheral arteries was reduced by approximately 95%. This reduced blood flow was accompanied by a vaso-constriction which increased the peripheral resistance to blood flow. The toes were most often affected and showed an increase of 400 peripheral resistance units. The possibility that this phenomena is an initiating factor of the commonly observed peripheral gangrene in the toes, was suggested by Dr. Selman.

"Passage of Drugs Across Cell Boundaries"

Dr. L. S. Schanker of the National Heart Institutes delivered a paper reporting new findings on the "Passage of Drugs Across Cell Boundaries" June 24 at the Sixth National Medicinal Chemistry Symposium of the American Chemical Society, held on the University of Wisconsin campus.

Dr. Schanker traced the history of past classical studies of how foreign compounds penetrate cells. The studies, he said, developed the idea that a cell boundary consists of a membrane of fatty material with many pores, giving it a a sieve-like construction.

Three theories of foreign molecule (drug) passage were developed on the basis of the classical studies, he pointed out: the foreign cells may dissolve in the fatty structure and migrate across by simple diffusion; they may pass through the sieve-like holes, provided the molecular dimensions fit; and there may be absorption via active transport mechanisms—the cell specifically absorbs a given molecule.

Following the review of the classical studies on the topic, Dr. Schanker reported on his own research in the absorption of drugs by the lining of the stomach and the intestine.

Dr. Schanker revealed that the greatest absorption occurs when the drug molecule is in a form that has greatest solubility in the fatty materials of the cell boundary. Drugs which are mildly acid or alkaline receive greatest absorption when the drug is in unionized form, he stated.

On the basis of these findings, it was concluded that mild acids, like aspirin, absorb best in an acidic stomach, while mild bases, such as quinine, absorb best in the intestine, which is neutral to slightly alkaline.

These new considerations are of value to the medicinal chemist in predicting drug absorption and to the pharmacist in preparing suitable vehicles for drug administration, Dr. Schanker pointed out.

The Mobile Unit X-ray Survey in Cardiovascular Disease Detection

A Report of 129,894 70 mm. X-rays, 3,477 Referrals

By MILTON FEIG, M. D., DONALD C. CAMERON, M. D., and AGNES JENSEN, R. N.

Madison

INTRODUCTION

THIS report deals with the cardiovascular findings from 129,894 70 mm. chest x-ray films taken during 1955 by the State Board of Health mobile x-ray units. At least one prior study[1] on the pulmonary aspects of Wisconsin's mass miniature x-ray program has been published. However, the growing importance of diseases of the heart and blood vessels has focused attention on the development of effective case-finding methods for this disease group and evaluation of existing programs.

It is hoped that this report will serve to demonstrate the effectiveness of Wisconsin's mobile x-ray program in heart disease detection to the practicing physicians and local health agencies who are responsible to a large degree for whatever success this program has achieved.

SURVEY METHOD

In general, the survey method in 1955 was the same as it was in the period 1949–1951, described in the report of Feig and Jensen.[1] Referrals for suspected cardiovascular diseases were made *only* on the basis of the 70 mm. x-ray film readers' impressions; no formal table of criteria for heart size or shape, etc., was established. Individuals suspected of having cardiovascular disease were referred directly to their family physician, who was also notified of the film impression. The follow-up was completed when it was determined from the physician whether or not the film readers' impressions were confirmed by further examination. Individuals on whom this follow-up data could not be obtained were considered in the "unconfirmed" group. However, it was not requested of the physicians that specific diagnostic terms be used, and therefore information as to the etiology of the confirmed cases is not available.

Although the program is aimed at the general public, some qualifying remarks must be made about the survey population in this study. Firstly, children under the age of 15 are not x-rayed unless exposure to tuberculosis is known to have occurred, for the incidence in this age group ordinarily is very low. Secondly, it is a policy of the Board of Health to encourage industrial groups to participate in the screening program, for tuberculosis has had a relatively high incidence in males over 45 years of age. Thirdly, all films taken in mental institutions, homes for the aged, and general hospitals have been deleted from this study population. These last two qualifications have a definite bearing on the study of the cardiovascular aspects of the x-ray survey, as they tend to insure a relatively young and able-bodied, well population for study.

The first study[1] seemed to indicate that the 70 mm. x-ray survey may be of considerable value in detecting heart disease. Therefore, beginning in 1955, each screenee was asked to state whether or not he had heart disease or hypertension. This question was introduced into the program for the specific purpose of classifying each case of confirmed heart disease discovered through the screening x-ray film as either a "known" case or a "new" case. If a confirmed case of heart disease had stated at the time of the original screening x-ray that he had heart disease, this was considered a "known" case. On the other hand, if a confirmed case of heart disease had stated that he had no heart disease, this was assumed to be a "previously unknown" or "new" case. Persons who left this question unanswered were classified in a "no data" group. The value of the 70 mm. x-ray in heart disease detection can then be calculated roughly in terms of the number of "new" or "previously unknown" cases dis-

TABLE I—YIELD OF 1955–56 MOBILE UNIT X-RAY SURVEY IN WISCONSIN IN TERMS OF CASES OF HEART DISEASE CONFIRMED OR NOT CONFIRMED, 129,894 X-RAYS, 3,477 REFERRALS. (EXCLUDING INSTITUTIONS)

No. Films	No. Cardiac Referrals	Heart Disease Confirmed				Heart Disease Not Confirmed (Follow-up Negative or Incomplete)	
		No.	% of Referrals				
			Pos. Hist.	Neg. Hist.	Total	No.	% of Referrals
129,894	3,477	1,648	59.8	42.8	47.5	1,829	52.9

covered, for these individuals could now receive the benefits of earlier treatment. Also, "old" cases could be encouraged to return to the care of their family physician should they so desire—a benefit not to be overlooked in evaluation of the program.

FINDINGS

From the 129,894 70 mm. chest x-rays taken in this survey, a total of 3,477 were considered by the readers to show evidence of heart disease, and these people were therefore referred to their family physicians for further investigation. It can be seen in Table I that in 1,648 (47.5 per cent) of these referred cardiovascular suspects, the presence of heart disease was confirmed by the family doctor. Notice, also, that the film readers' suspicions were verified in 59.8 per cent of those referrals who had given a positive history of heart disease. In both instances the degree of confirmation after referral is high. In such groups the confirmation rate is higher than in persons referred for tuberculosis and other pulmonary disease.

In Table II is demonstrated an interesting finding. It is not surprising that a considerable number (2,537) of the screened population who had suspicious 70 mm. films apparently had no knowledge of existing heart disease; actually, this "unaware" group is the real objective of such a program as the one described here. However, it was quite unexpected that of the 6,244 persons who had positive cardiovascular histories, only 940 (15 per cent) had suspicious 70 mm. x-rays.

TABLE II—DISTRIBUTION OF POSITIVE AND NEGATIVE CARDIOVASCULAR HISTORIES WITH RESPECT TO 70 MM. X-RAY FINDINGS, 129,894 X-RAYS, 3,477 REFERRALS. (EXCLUDING INSTITUTIONS)

	Abnormal 70 mm. Cardiac Findings	Negative 70 mm. Cardiac Findings	Totals
Negative History	2,537	116,611	119,148
Positive History	940	5,304	6,244
Totals	3,477	121,915	125,392*

*4,502 "no-data" persons bring this figure to 129,894, the total number screened.

Speculation as to the meaning of this rather striking finding suggests several possible answers. First, there can be no doubt that a certain portion of this apparent contradiction is due to a "heart-conscious" attitude in the screened population. Also, estimation of abnormalities of cardiac size and shape on x-ray film frequently presents great difficulty, and it is well recognized that not all heart disease manifests itself on x-ray film. However, it may be that the real meaning of the discrepancy goes beyond this. Approximately 70 per cent of those who had negative 70 mm. x-rays, and yet indicated a positive cardiovascular history, in fact, gave a positive history for hypertension. Thus, it would seem likely that we are missing with our single investigative technique a considerable and significant portion of the cardiovascular disease in our screening population, specifically, hypertension. Moreover, this large group with no x-ray evidence of cardiac abnormality would seem to be those individuals who could best be helped by early verification of their hypertension and benefited by early treatment. It also indicates that establishing a satisfactory screening test for hypertension would be a most fruitful activity among the large, apparently well population group unaware of such illness. Such a screening activity could well become a major public health factor in bringing these people to the early medical care of their family physicians.

Table III presents the final results of the 1955 chest x-ray program in a summary fashion. As might be expected, the number of referrals increases in direct proportion to the age of the group being studied. The number of confirmed cases of heart disease increases in the same way, as does the rate of confirmed cases per 1,000 referrals.

It is of particular interest that the number of cases of confirmed heart disease first detected by 70 mm. chest x-ray in persons with

negative cardiovascular history exceeds in all age groups the number detected in persons with positive cardiovascular histories, and in most instances this difference is of a considerable degree. A total of 562 referrals in persons with a history of heart disease were verified by the family doctor. Almost twice as many (1,086) cases were confirmed among those referrals who gave a negative cardiovascular history.

Included in a separate column in Table III are those persons who were referred to their physicians because of 70 mm. x-ray findings suggestive of pulmonary tuberculosis, cancer, or some other pathology not related to cardiovascular disease, but in whom heart disease was detected by the family doctor during the course of his examination. These persons had no previous knowledge of heart disease and totaled 191.

Included in Column V are a number of persons with known heart disease who were referred for pulmonary findings, and in whom the doctor "reconfirmed" the existence of heart disease. This accounts for the apparent discrepancy between the figures in Column I and Column V.

In order to make more meaningful the cardiovascular results of this x-ray screening program, we have used in Table III the terms "Old Heart Disease" and "New Heart Disease." These, of course, have no reference to the length of duration of the disease. By "old" heart disease is meant disease that was previously known to the screenee. "New" heart disease, on the other hand, refers to disease which was previously unknown or unrecognized by the screenee, and which was discovered as a direct consequence of the screening examination.

The point in using these terms is that they capture the significance of the screening program—the discovery of "new" or previously unrecognized disease. Table III demonstrates that 627 cases of "old" heart disease were detected by 70 mm. chest x-ray in the base population of 129,894; this is a rate of *4.8 per 1,000 persons screened*. On the other hand, this technique of examination was directly or indirectly responsible for the discovery of 1,277 persons with "new" heart disease, which represents a rate of *9.8 new cases per 1,000 films*. In all, then, the 1955 70 mm. x-ray survey resulted in the x-raying of 129,894 persons, of whom some 3,477 were referred to their doctor because of cardiovascular findings on their 70 mm. x-ray picture; of these, 1,904 were verified as having heart disease, which is a rate of 14.6 per 1,000 x-rays taken.

DISCUSSION

The usefulness of the 70 mm. chest x-ray as a cardiovascular disease case-finding mechanism remained undiscovered, apparently, until 1950 or so, judging from the burst of reports on this subject which entered the literature at about that time. Since

TABLE III—SUMMARY OF ALL PHASES OF THE CARDIOVASCULAR DIAGNOSES AFTER REFERRAL THROUGH THE 1955 MOBILE X-RAY SURVEY IN WISCONSIN. (EXCLUDING INSTITUTIONS)

Age	No. Films	Cardiac Referrals	CV Disease Suspected on 70 mm. Film and Confirmed on Follow-Up						CV Disease Discovered on Follow-Up for Other Reasons (Negative CV History) Col. IV		Total "Old" HD Col. V		Total "New" HD Col. VI		Total HD Detected Col. VII	
			CV History Positive Col. I		CV History Negative Col. II		Totals Col. III									
			No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
Under 19	25,157	180	13	.5	41	1.6	54	2.1	8	.3	13	.5	49	1.9	62	2.4
20–29	20,894	143	19	.9	32	1.5	51	2.4	8	.4	20	1.0	40	1.9	60	2.9
30–39	26,659	218	25	.9	65	2.4	90	3.4	9	.3	27	1.0	74	2.8	101	3.8
40–49	24,431	453	41	1.7	135	5.5	176	7.2	26	1.1	46	1.9	161	6.6	207	8.5
50–59	16,842	886	135	8.0	287	17.1	422	25.1	40	2.4	149	8.9	327	19.4	476	28.3
60–64	6,503	481	73	11.2	173	26.6	246	37.8	37	5.7	85	13.1	210	32.3	295	45.4
65+	9,330	1,102	254	27.2	348	37.3	602	64.5	61	6.5	285	30.5	409	43.8	694	74.3
Unknown	78	14	2	-------	5	-------	7	-------	2	-------	2	-------	7	-------	9	-------
TOTAL	129,894	3,477	562	4.3	1,086	8.4	1,648	12.7	191	1.5	627	4.8	1,277	9.8	1,904	14.6

Note: Column I does not equal Column V because Column V includes a number of cases referred for other reasons in which HD was known and reconfirmed.
Note: Rates expressed as number per 1,000 x-rays.

then the subject has been actively explored and a number of interesting and valuable papers have been presented.

There is a considerable variation in the yields quoted in these reports; differences in referral criteria, the characteristics of the surveyed population, and perhaps the "cardiac awareness" of the film readers are a few of the many factors which are responsible for these variations. In a very large series of 1,736,703 films taken in Los Angeles, Jacobson and his group[2] discovered 3,388 cases of confirmed heart disease. This is a rate of 1.8 confirmed cases per 1,000 films; of these 0.4 per 1,000 were new cases, 0.4 per 1,000 were old cases returned to medical care, and 1.0 per 1,000 cases were old cases already under care.

On the other hand, considerably greater yields are reported by other authors. Weinerman, *et al.*,[3] discovered 19 cases of heart disease per 1,000 persons screened by 70 mm. x-ray, and 8 per 1,000 were new cases. Similar results are presented by Rutstein, Williamson, and Moore,[4] who detected 16 cases per 1,000 films, of which 9 were new cases. Schwartz and Berman's[5] findings were almost identical to those of Rutstein and his associates.

The survey presented here, with its overall, case-detection rate of 14.6 cases per 1,000 films, compares quite favorably with any of the reports in the literature. The one significant difference between these findings and others is that the ratio of new cases to old cases detected in the Wisconsin program was 2:1 compared with a ratio of 1:1 in other reports.

The benefits derived from such screening programs, as have been described here, are not recognized by all. The most frequent argument opposing the use of mass screening techniques is the apparent high cost of detecting so few cases of heart disease. Actually, this is an argument for making greater efforts to increase the efficiency of our techniques rather than being an argument against this type of activity. It must also be emphasized that in the State Board of Health program this cardiovascular aspect was secondary to tuberculosis screening and entailed no additional costs.

The ultimate test of the value of this type of case-finding is whether or not it is successful in reducing and delaying disability and death due to heart disease. This, of course, is a difficult matter to assess; and until this year there was no answer available, to be given to doubters, which was based on statistical data rather than on personal experience and faith. In this connection, we owe a debt of gratitude to Stewart, Kordan, and Enterline[6] for their timely report on a recently completed 70 mm. x-ray survey in California and Texas. These authors concluded that during the three-year period following the x-ray survey program, the persons identified as having heart disease received medical and nursing care which reduced their mortality rate approximately 15 per cent. It would not seem unreasonable to assume that the amount of disability was reduced a like amount or even more.

CONCLUSION

The facts presented in this study indicate that the 70 mm. chest x-ray is a useful and effective mechanism for heart disease screening. Further, it is suggested that the addition of a screening test for hypertension to the 70 mm. x-ray program should be of considerable value in bringing many persons to early medical care, thereby prolonging life and lessening disability. There is an additional benefit to be gained from this latter activity which is deserving of more attention than the mere mention it receives here, namely, the contribution that this sort of data will make toward a more accurate and realistic estimation of the prevalence of cardiovascular disease in the general population than is presently afforded by a mere tabulation of death rates.

SUMMARY

The results of the 1955 70 mm. mobile unit chest x-ray survey in Wisconsin are analyzed with respect to cardiovascular disease detected. A total of 129,894 films were taken, 3,477 referrals were made, and 1,904 cases of heart disease were confirmed, for a detection rate of 14.6 cases per 1,000 x-rays.

State Board of Health, State Office Building.

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SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

On April 1, 1958, the March of Medicine began its thirteenth consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin, discussing various health problems with a lay person who is called "Your Medical Reporter." At present 38 stations in Wisconsin are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Day*	*Time*
WATK	Antigo	Saturday	8:45 a.m.
WATW	Ashland	Saturday	4:45 p.m.
WGEZ	Beloit	Saturday	10:45 a.m.
WCHF	Chippewa Falls	Saturday	12:45 p.m.
WBIZ	Eau Claire	Sunday	7:00 p.m.
WEAU	Eau Claire	Saturday	11:45 a.m.
KFIZ	Fond du Lac	Thursday	7:15 p.m.
WBAY	Green Bay	Saturday	5:15 p.m.
WTKM	Hartford	Tuesday	11:00 a.m.
WCLO	Janesville	Tuesday	8:15 p.m.
WLIP	Kenosha	Saturday	9:05 a.m.
WKBH	LaCrosse	Saturday	10:45 a.m.
WLDY	Ladysmith	Saturday	9:00 a.m.
WHA	Madison	Friday	10:30 a.m.
WIBA	Madison	Saturday	11:15 a.m.
WOMT	Manitowoc	Saturday	9:15 a.m.
WDLB	Marshfield	Saturday	9:45 a.m.
WIGM	Medford	Saturday	10:00 a.m.
WEKZ	Monroe	Saturday	1:45 p.m.
WCCN	Neillsville	Saturday	9:30 a.m.
WPFP	Park Falls	Saturday	10:45 a.m.
WSWW	Platteville	Saturday	9:05 a.m.
WPDR	Portage	Thursday	10:15 a.m.
WIBU	Poynette	Thursday	2:30 p.m.
WPRE	Prairie du Chien	Saturday	10:15 a.m.
WRJN	Racine	Sunday	6:30 p.m.
WRDB	Reedsburg	Saturday	12:45 p.m.
WOBT	Rhinelander	Saturday	10:15 a.m.
WJMC	Rice Lake	Saturday	9:45 a.m.
WRCO	Richland Center	Saturday	5:15 p.m.
WCWC	Ripon	Saturday	9:15 a.m.
WTCH	Shawano	Sunday	6:45 p.m.
WDOR	Sturgeon Bay	Thursday	10:45 a.m.
WTRW	Two Rivers	Saturday	9:45 a.m.
WTTN	Watertown	Tuesday	11:30 a.m.
WSAU	Wausau	Saturday	5:15 p.m.
WBKV	West Bend	Saturday	11:15 a.m.

Sublingual Cysts*

By ARNOLD S. JACKSON, M. D.

Madison

THE paucity of knowledge concerning sublingual cysts may be judged from the fact that a search of over 20 American surgical texts revealed little or nothing on the subject.

If the general surgeon is confronted with such a problem, he must either turn to the *Archives of Otorhinolaryngology* or to the foreign literature to enhance his knowledge. Although this condition is most unusual and I have encountered only three cases in the past four decades, one might be confronted with the problem at any time. Consequently, it is well to know something about the differential diagnosis, the treatment, and the prognosis.

The literature contains reports of the following types of cysts of the floor of the mouth: dermoid cyst, ranula, hygroma, and thyroglossal cyst. My report adds three cases, an epidermal cyst and two dermoid cysts.

Dermoid cysts are the most prevalent and may be located either above or below the mylohyoid muscle. These cysts may attain such size as to push the tongue back against the pharynx and interfere with breathing and swallowing. This was true of the cases in this report. The cysts may attain the size of a lemon and give a characteristic appearance to the submental region. They tend to be thick-walled and spherical and have a doughy feeling. Occasionally they may rupture intraorally or externally. Once they become infected, they may cause repeated inflammatory swelling and discharge their contents by a sinus into the floor of the mouth. While this condition may simulate an infected salivary gland, the latter is situated to one side, while the dermoid cyst is generally in the midline.

Ranulas are thin-walled, epithelial-lined cysts situated in the anterior part of the floor of the mouth. They grow slowly, may be bluish in color and are soft in consistency. Unlike dermoid cysts, they fluctuate and do not pit on pressure. They are further differentiated by the thinness of their walls.

Hygromas are generally located in the neck but rarely may occur in the floor of the mouth. They are multilocular cysts, are extremely thin-walled, and contain clear lymph. They are endothelial-lined and are retention cysts resulting from a failure of development or an obstruction of the lymph channels. Surgical removal of these cysts, particularly if they are bilateral, may be attended with considerable risk; and there are reports of some cases responding successfully to external radiation therapy.[1] Although I have successfully operated upon several cases of hygromas located in the neck, I have not observed one located in the sublingual area. Lymphangioma and hemangioma of the floor of the mouth present the same clinical picture but are distinguished by the color of the angioma and the granular appearance of the lymphangioma.

Thyroglossal cysts are generally located in the neck below the hyoid bone where they cause a swelling in the midline. However, they may become infected and cause inflammatory swelling at the base of the tongue. Surgical removal is indicated after the method first described by Sistrunk.[2]

CASE REPORTS

Case 1—A 9-year-old boy had been seen for the first time eight months previously because of a small sublingual cyst noticed a few weeks before. As the cyst had been causing no symptoms, surgery was postponed until the end of the school year. However, in the next few months the cyst had grown rapidly and within eight months had attained such size as to seriously interfere with breathing and swallowing, thus necessitating immediate surgical relief.

On May 15, 1957, operation was performed under intratracheal anesthesia. A transverse incision 6 cm. long was made over the base of the cyst, and the cyst was gently shelled out of its bed intact without difficulty and with a minimum of bleeding. The muscles were then closed with 0000 plain catgut, and the mucous membranes with interrupted sutures. The incision was closed without

* Presented at meeting of the Wisconsin Surgical Society, Madison, September 20, 1957.

From the Jackson Clinic, Madison.

Fig. 1—Nine-year-old boy with sublingual cyst.

drainage, contrary to recommendations in the literature. Convalescence was uneventful.

The pathologic report by Dr. Etheldred L. Schafer was as follows:

> Gross description: Specimen consists of an ovoid, fluctuant cyst measuring 7 x 5 x 4 cm. The surface is pinkish-red, vascular, and roughened by delicate tags of areolar connective tissue. Section reveals a thin wall and luminal contents that are pale tan and mushy. The inner lining is relatively smooth and translucent.
>
> Microscopic description: Section shows a vascular, fibrous-walled cyst lined by keratin-forming, stratified, squamous epithelium consistent with an epidermal cyst.

Case 2—A 22-year-old female came to the clinic on January 2, 1931, complaining of a small growth beneath the tongue which had been present since birth. This had gradually increased in size until recently it had caused some difficulty in speech and in swallowing. Growth had been rapid the last year. Examination showed a large sublingual cystic growth causing some dyspnea and dysphagia. The cyst was soft and compressible. It had a yellowish tinge and crowded the tongue up against the pharynx.

Operation was performed under general anesthesia. A transverse incision was made at the base of the cyst and the cyst was removed intact with very little bleeding. Convalescence was uneventful. The pathologic report showed this to be a dermoid cyst.

Fig. 2—Sublingual cyst before removal.

Case 3—A 17-year-old female came in December 27, 1932, because of a swelling under the chin. This lump had first been noticed one year previously, and there had been a gradual increase in size. It had caused the speech to be a little thicker. Examination revealed a large cystic mass beneath the tongue forcing the tongue up into the roof of the mouth and also causing a swelling in the submental area. This was a soft, fluctuant cystic mass and was diagnosed as a sublingual cyst.

Fig. 3—Sublingual dermoid cyst.

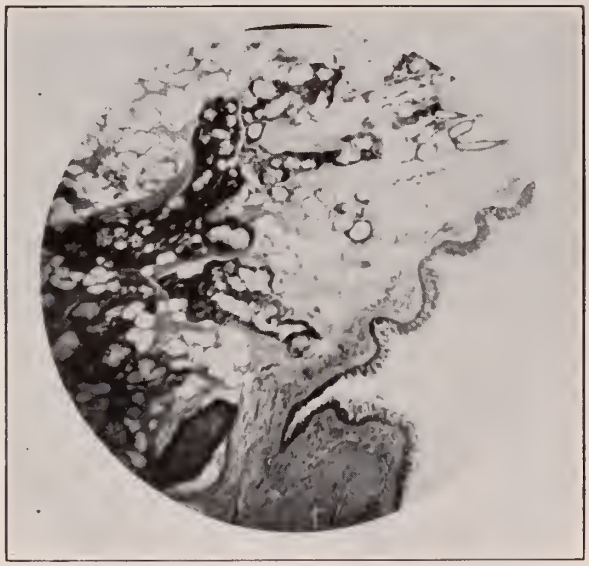

Fig. 4—Microscopic section showing ciliated columnar and stratified squamous epithelium and mucous and sebaceous glands.

Operation was performed December 28, 1932, under local anesthesia. Procaine with epinephrine was injected at the base of the cyst, using the fluid as a hydrostatic dissector. Through a transverse incision the cyst was then carefully shelled out of its bed and removed without rupture. The cyst was opened and found to contain a yellowish colored, cheesy material. The cavity was closed with 000 chromic interrupted suture without drainage, and convalescence was uneventful.

The pathologic report was a typical sublingual dermoid cyst.

CONCLUSIONS

Sublingual cysts are rare and only a few cases are reported in the literature.

They may be dermoid cysts, hygromas, ranulas, thyroglossal cysts, or epidermal cysts. All are congenital in origin.

Clinical differentiation is difficult.

Two cases of dermoid cysts and one epidermal cyst are reported in this presentation.

The treatment is surgical excision.

30 South Henry Street.

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UW MEDICAL SCHOOL RECEIVES GRANT FOR POSTGRADUATE MEDICAL EDUCATION

The University of Wisconsin Medical School has received a grant of fifty-one thousand dollars ($51,000.00) from the W. K. Kellogg Foundation in support of the Medical School's program of postgraduate medical education. The grant will extend over a period of four years.

With the help of this grant, the Medical School expects to revise its program of postgraduate medical education to offer more services to a larger number of physicians. Five postgraduate courses are planned for the 1958–59 academic year. They will be presented as follows:

1. **"Recent Advances in Anesthesia and Resuscitation"**, a one and one-half day course to be presented on October 10 and 11. Course director—Dr. O. Sidney Orth.
2. **"General Practice 1958"**, November 6, 7 and 8. Course to feature participation by departments of Medicine, Surgery, Pediatrics, Obstetrics–Gynecology and Psychiatry.
3. **"Hematology and Hypertension"**, March 19, 20 and 21. Course director—Dr. Ovid O. Meyer.
4. **"Problems of the Newborn Period"**, April 2, 3 and 4. Course director—Dr. Nathan Smith.
5. **"Pathology and Roentgenology of the Skeletal System"**, May 21, 22 and 23. Course co-directors —Dr. D. Murray Angevine and Dr. Lester W. Paul.

The grant from the Kellogg Foundation will be used to secure visiting speakers for these postgraduate courses, and to present special services to the physicians who register for this instruction. It is also planned to inaugurate some new types of postgraduate instruction aimed especially at working with hospital staffs throughout the state.

The Medical School is pleased that it will be able to offer a more intensified postgraduate program, and hopes to be of increased service to the medical profession.

Comments on Treatment

Editors—F. E. SHIDEMAN, M. D., University of Wisconsin, Madison
HARRY BECKMAN, M. D., Marquette University, Milwaukee

Antimalarials and Arrhythmias

The effectiveness of quinidine in the treatment of certain cardiac arrhythmias is well established. The usefulness of this compound was demonstrated subsequent to the successful application of cinchona and quinine in atrial fibrillation. A number of the synthetic antimalarial drugs containing the quinoline nucleus also possess antifibrillatory activity and quinacrine has been used with success, both experimentally and clinically, in atrial flutter and fibrillation and ventricular tachycardia. Its toxicity apparently has limited its application on a wider scale.[1]

Arora[2] in 1955 examined a number of cinchona alkaloids, cupreines and synthetic antimalarials for their capacity to antagonize the response to veratridine in the sartorius muscle of the frog. He found the entire series of 19 compounds studied possessed such antiveratrinic activity. The most potent of the group were chloroquine and amodiaquin (Camoquin®), both being 4-aminoquinolines. It was further noted that the activity of the series in antagonizing the veratrine response was paralleled by their potency in depressing the isolated frog heart. As a result of these observations chloroquine was compared with quinidine as an antifibrillatory agent in experimentally induced arrhythmias.[3] It was found to be one and one-half times as potent as the latter drug in prolonging the refractory period in rabbit auricles and more effective in arresting either acetylcholine or electrically induced auricular fibrillation. Both agents produced comparable electrocardiographic changes in the cat. These findings led the authors to recommend its trial in the treatment of arrhythmias observed in man.

In the first reported series of cases of arrhythmias in which chloroquine was employed the results appeared promising.[4] Oral administration of the drug resulted in a restoration of normal rhythm in a large percentage of patients with supraventricular tachycardia, multifocal ventricular extrasystoles or atrial fibrillation. The incidence of side effects was small. Subsequently Sanghvi[5] utilized 250 mg. of chloroquine, intravenously, in two cases of auricular fibrillation, converting the fibrillation to flutter without restoring normal rhythm. Administration of larger amounts of the drug produced ventricular premature beats. When quinidine was administered orally at a later time a normal sinus rhythm resulted. He concluded that chloroquine is more toxic and less effective than quinidine. It is to be noted that such conclusions were based on a series of only two cases and different routes of administration were employed for the two drugs. The more recent studies of Burrell and Martinez[6] tend to confirm the earlier work of Sanabria[4] and contradict the conclusions drawn by Sanghvi.[5] The first-named investigators reported restoration of normal sinus rhythm or reduction of ectopic beats by 75 per cent or more in 50 of 73 arrhythmias following the oral administration of chloroquine or hydroxychloroquine. Initially 1 gm. per day in divided doses was given and increased by 0.25 gm. per day every third day until gastrointestinal side effects made cessation of therapy necessary. A satisfactory response was observed in 23 of 44 cases of auricular fibrillation and in over 85 per cent of those individuals with premature ventricular contractions. In the entire series of 64 patients only one death occurred and it was not possible to determine whether the drug or the disease process was the cause. Otherwise, side effects were reported to be limited and less marked than those observed with quinidine.

It is a bit premature to advocate the use of chloroquine in preference to such a well established drug as quinidine. However, the experimental data and the promising clinical results obtained with its oral usage would suggest that it might be a useful addition to this category of cardiovascular agents, particularly if, as reported by Burrell and Martinez, certain arrhythmias which are refractory to quinidine and procaine amide respond to chloroquine.—F. E. SHIDEMAN, M.D.

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Pococurantism*

Frontiers exist in medicine.

The nucleus of a major health problem, bodily injuries and traumatic deaths, is tersely described in the definition of pococurantism, a rarely used English word taken from the Italian language and derived from two Latin words: paucus meaning little, and curare, to care. Pococurantism is a state of mind that cares little. It is an attitude of indifference, of disinterest, of apathy and of mental indolence.

The acceptance of the solution for a health problem, in the final analysis, is determined by the attitude of the people to that problem. The general public is not interested in preventing injuries and traumatic deaths. Metaphorically, pococurantism is the obstacle over which educational programs designed to prevent injuries stumble and fail. Time after time safety projects are initiated by experienced organizers with well-developed and costly plans, and set into motion with appropriate publicity. Tragically, their momentum is slowed to an almost dead stop by this universal, invisible and underestimated human proclivity to care little.

Pococurantism is inherent in everyone. Its degree varies with individuals and in their reactions to different problems and situations. If one accepts the premise that the single basic biological factor in the motivation of behaviour is the necessity of meeting the bodily requirements of survival, hence, if one's behaviour leads to injury and death, pococurantism becomes pathological and should be classified as a disease.

The study of diseases, their causes, treatments and preventions has been accepted by the medical profession as their ethical responsibility. The purposes for the study of both diseases and injuries are threefold: to find a definitive cause, a specific therapy, and a way of prevention.

The pattern for the study of diseases has been fashioned by time. It is a story of medical leadership. Today as in the past, it begins with the clinical observations by the physician of the symptoms and signs in his patient and the results of empirical methods of treatment. The pattern expands through experimentation in the laboratories, in animals and in man. In order to attain the maximum development of this pattern, high and uniform standards of education for doctors of medicine had to be established. The achievements of this system warrant its application to the exploration of unsolved health problems.

For the patient and his family there is no difference between a disease and an injury. However, a different pattern for the study of injuries and traumatic deaths has been molded by time. Leadership is divided. Today as in the past doctors treat, and more recently, safety groups have organized for prevention activities. The treatment of injuries is on a par with that for diseases. Although the medical profession has assumed the responsibility for therapy it leaves the study of both ends of the problem, cause and prevention, to lay individuals. The lay safety groups handicapped by lack of contact with injured patients have been trying to bridge the gap between causation and prevention. These groups have reached a conclusion logical to them that injuries are caused by lifeless objects. Preventive advice has been directed accordingly. The role of human behaviour as a factor has received little attention.

There is so much hidden drama in a broken bone from a slip on a scatter rug that its challenge passes over our heads. The doctor is content to apply a cast and the safety groups to recommend that an inanimate scatter rug be fastened down. If the prevention of the injury was merely to fasten the rug down, injuries and traumatic deaths would not be a major health problem. The solution is more complex than that.

The study of injuries and traumatic deaths, their causes, treatments and preventions is the moral responsibility of the medical profession.

Clinicians agree that patients are interested in preventing diseases but not injuries. What are the

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* Reprinted from March, 1957, News-Letter of American Academy of Pediatrics. Written by Robert H. Kotte, M. D., liaison representative to National Safety Council.

Suggestions for Management of Rabies

As It Looks to Your State Board of Health

IN RECENT years rabies in Wisconsin has become more prevalent among skunks and other wild animals than in dogs. There have been two positive findings among bats which bit humans. During the summer a large number of local residents as well as tourists are exposed to the danger of bites by these animals—and every bite by a mammal is a potential source of rabies infection.

General recommendations following an animal bite include detention and observation for 14 days by a competent veterinarian of the offending dogs and cats. Wild animals should be captured and killed and the head packed in dry ice and sent to the State Laboratory of Hygiene for rabies examination.

W.H.O. recommendation for management of possible rabies exposure follows:

TABLE I.

Nature of Exposure	Condition of Biting Animal		Recommended Treatment (Note: Local Treatment Should be Given)*
	At Time of Exposure	During Observation Period of 10 Days	
I. No lesion; indirect contact only	rabid	----------	none*
II. Licks:			
(1) unabraded skin	rabid	----------	none*
(2) abraded skin, scratches and unabraded or abraded mucosa	a) healthy	healthy	none*
	b) healthy	clinical signs of rabies or proven rabid (laboratory)	start vaccine at first signs of rabies in animal*
	c) signs suggestive of rabies	healthy	start vaccine immediately. Stop treatment if animal is normal on 5th day after exposure*
	d) rabid, killed, escaped or unknown	----------	start vaccine immediately*
III. Bites			
(1) mild exposure	a) healthy	healthy	none*
	b) healthy	clinical signs of rabies or proven rabid (laboratory)	start vaccine at first sign of rabies*
	c) signs suggestive of rabies	healthy	start vaccine immediately. Stop treatment if animal is normal on 5th day after exposure*
	d) rabid, escaped, killed or unknown; or any bite by wolf, jackal, fox, bat or other wild animal	----------	start vaccine immediately*
(2) severe exposure: multiple, or face, head or neck bites	a) healthy	healthy	serum immediately; no vaccine as long as animal remains normal
	b) healthy	clinical signs of rabies or proven rabid (laboratory)	serum immediately; start vaccine at first sign of rabies
	c) signs suggestive of rabies	healthy	serum immediately, followed by vaccine; vaccine may be stopped if animal is normal on 5th day after exposure
	d) rabid, escaped, killed or unknown. Any bite by wild animal	----------	serum immediatley, followed by vaccine

*Note: **The great importance of local treatment is re-emphasized, and the ideal local treatment includes infiltration with antirabies serum along with thorough cleansing of the wound using tincture of green soap or other antiseptic detergent. The dose of serum used in local infiltration will be dictated chiefly by the site of the bite. However, where possible not less than 5 ml. should be used.

The general principles on which the above guide is based are that in mild exposures a course of vaccine following the above recommended local treatment is sufficient, whereas following severe exposure the full systemic dosage of antirabies serum together with vaccine should be employed. In such systemic use of serum, although it is recognized the

** Excerpt from the third W.H.O. Technical Report Series, January 16, 1957.

earlier the treatment is started the better, there is no time limit after exposure to this recommendation. For the reasons stated in section 2.3 (of the report) serum should be administered in a single dose (0.5 ml. per kg. of body-weight) at the start of treatment followed by a course of no less than 14 daily doses of vaccine.

Sensitivity to serum should be tested before any use of serum.

It is readily recognized that in certain situations specific conditions may warrant modifications of the above guide, *e.g.*, exposure especially in young children or where a reliable history cannot be obtained, and particularly in areas where rabies is known to be endemic even though the animal at the time of exposure is considered to be healthy. Such cases may justify treatment immediately in a modified way. One possible modification is that following local treatment of the wound described above, two or three doses of vaccine be given at daily intervals and no further doses as long as the animal stays healthy for 10 days following exposure.

In shipping the animal for rabies examination pack only the head of the animal in a clean can. Seal and pack with ice, or dry ice, in a larger can. Ship by express or bring to the laboratory. *DO NOT MAIL.* Information should be supplied concerning persons bitten, giving the location and severity of the wounds, and a history of the animal.

It should be emphasized at this point that the above table is only a guide and that certain circumstances may justify its modification.—JOSEF PREIZLER, M.D., M.P.H.

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reasons for this difference in their attitude? People are afflicted with pococurantism. Why? This is a subject for clinical research. The person best qualified to initiate the study of pococurantism is the physician. He sees the patient; uses forms of therapy that have been developed by the pattern fashioned by time for the study of diseases; and is in a strategic position to make pioneer observations of the human element in this perplexing problem. His findings may point a way for prevention.

Observations are not enough. The doctor must be vocal. He should discuss informally his observations and deductions as he does those of diseases with his colleagues in the corridors of the hospitals and at meetings. Eventually, the inertia on the part of the medical profession to this vexing question will be overcome. The momentum will increase until the study of all phases of injuries has taken its rightful place alongside that of diseases in medical education, in practice, and at medical meetings.

Leadership will have been started in the study of bodily injuries and traumatic deaths as it is in diseases with the clinical observations by the physician. The pattern should expand through research. The findings should be given to the safety organizations so that their splendid facilities already in existence could be used for educational preventive programs.

Progress can be made in no other way.

Correspondence

Dear sir:

I truly thank you for sending me the Wisconsin Medical Journal for the past several months. In June I will be leaving Wisconsin and I feel that you no longer need to send my Journal after June 15th.

In reading your magazine I have found some very interesting and informative articles which, I am sure, will be of value to me in future years.

Sincerely yours,

STUART CASE
Senior Medical Student
Marquette Medical School

* * *

June 3, 1958

State Medical Society of Wisconsin
Gentlemen:

The League of Women Voters of Wisconsin in state convention action on May 20, 1958, voted to direct the State League Board to use every appropriate method in support of the establishment of a treatment center for emotionally disturbed children in Wisconsin, following the general principles jointly recommended by you, the University Medical School, and the Public Welfare Department.

The League wishes to extend its appreciation to the State Medical Society, the University Medical School, and the Public Welfare Department for working on this problem and for developing a set of general principles for the establishment of a treatment center; it recognizes the time and effort and the concern for public welfare which enter into an agreement of this nature.

Sincerely yours,

MRS. RALPH H. WENBERG
President
League of Women Voters of Wisconsin

Clinicopathologic Conference

Sponsored by the Section on Pathology, State Medical Society of Wisconsin
Guest Editor: Earl W. Cauldwell, M. D.

PRESENTATION OF CASE*

Dr. Harold W. Kishpaugh: This 66-year-old white man was admitted to the hospital at 2:10 P.M. December 14, 1957. He had become weak and fainted while on his way to the bathroom on the night prior to admission. For the previous two days he had several loose red-black stools, and on one occasion vomited dark brownish fluid. He had also experienced mild headache and a dull aching pain in the upper lumbar areas during this interval. He recalled having had a series of loose brown-black stools and one emesis of brown material one month previous to the present episode. For the past several months he had had intermittent episodes of dull epigastric and back pain, which apparently had no relation to activity or exertion. During the past one and one-half years he had noticed gradually increasing claudication in the left leg upon exertion, particularly during cold weather.

I saw this patient for the first time in March, 1933, with complaints of weight loss, fatigue, finger tremor, increased body warmth, and cardiac palpitation of four months duration. There was slight prominence of the eyeballs. The thyroid was palpable and of firm consistency. The palms of the hands were moist, and there was a fine tremor of the fingers. The urine and blood findings were normal. A diagnosis of toxic goiter was made, and the patient was placed on Lugol's solution. A subtotal thyroidectomy was subsequently performed. The pathologic diagnosis was adenomatous goiter. His postoperative course was relatively uneventful. He was not again seen by me until February, 1955, when he complained of a feeling of fullness in the head and frequent headaches. His blood pressure was 186/100. He was placed on Rauwolfia with good response.

* From Beloit Hospital, Beloit.

PHYSICAL EXAMINATION

On his current admission, physical examination disclosed a blood pressure of 122 systolic and 76 diastolic, oral temperature 99.2 F., pulse 86, and respirations 20 per minute. The skin was pale. The conjunctiva were also pale, the pupils round and equal, and the fundi negative. The nasal and buccal mucosa were moderately pale. There was normal mobility of the neck, and no palpable organs or masses. The thorax was symmetrical. Heart tones were normal, and the heart borders were within normal limits. There was normal respiratory expansion bilaterally, and absence of rales or abnormal breath sounds. The abdomen was flat and soft. There was a pulsating mass palpable in the left epigastric region, and this area was somewhat tender. This mass was estimated to measure roughly 6 by 4 inches. There was no abdominal rigidity. The liver and spleen were not palpable. The external genitalia were normal. There were no anal nor rectal abnormalities on digital examination. The stool on the examining finger was dark and blood-tinged. The extremities were symmetrical, and muscle function was normal. Femoral artery pulsations were present, but there was absence of pulse over the left dorsalis pedis artery. Superficial and deep reflexes were normal throughout.

LABORATORY EXAMINATION

The laboratory data were as follows: The hematocrit was 36 per cent and the hemoglobin 10.5 gm. The white blood cell count was 13,200, and the differential count included 66 neutrophils, 21 lymphocytes, 3 eosinophils, 1 basophil, and 9 monocytes. The urine was acid in reaction. The specific gravity was 1.016. Microscopic examination of the urine disclosed 0 to 2 white blood cells and an occasional red blood cell per high power field; occasional mucus threads; and few amorphous urates. The serological test for syphilis was negative.

A working diagnosis of upper gastrointestinal bleeding of undetermined etiology was made. On the afternoon of admission he was given one unit of whole blood. On the following morning, December 15, he passed a semisolid black stool containing streaks of blood. A flat film of the abdomen was taken in the afternoon with a portable radiographic machine.

Dr. R. F. Wilson (Radiologist): These were scout films taken without preparation of the patient. No definite abnormalities are seen. There is no evidence of an obstructing or deforming lesion of the colon. The terminal ileum appears normal. The stomach, duodenum, and jejunum are not adequately visualized. There was a palpable pulsating mass in the epigastrium on the left side. However, no outline shadow characteristic of the calcified wall of an aneurysm is discernible. When calcification is present, it often takes the form of a unilateral distinct line often sharply curved, located to either side of the vertebral column with its concavity directed toward the vertebral column. I don't feel that this film is very helpful in the differential diagnosis. Adequate preparation of the patient was requested, and further x-ray study was planned for the following day.

Doctor Kishpaugh: Although the film was of little diagnostic assistance, the radiologist did find the same left epigastric mass that I found on the initial examination. At 8:00 P.M., December 15, the patient's temperature rose to 102.2 F., and he complained of profound weakness. He was given salicylates with return of the temperature to normal. On the following morning, December 16, donnatol was administered. At 8:30 A.M., a saline enema was given with return of black blood-tinged fluid. He was sent to the Radiology Department at 11:20 A.M. A fluoroscopic examination and pre-evacuation films were made, during which time the patient's condition appeared satisfactory. He was then taken to the lavoratory for removal of the rectal balloon. A few minutes later he was found lying on the floor bleeding from the mouth. He was pulseless and dyspneic. Abundant clotted blood was evacuated from the oral cavity. He was immediately returned to his room, and an intravenous effusion of saline solution to which levophed was added, was begun. A unit of whole blood was given under pressure. The heart beat was detectable but he remained pulseless. The skin was pale and the nail beds cyanotic. Bloody mucus was aspirated from the nose and throat, and oxygen was administered. The profound degree of shock continued in spite of levophed and additional whole blood therapy, and the patient expired at 1:25 P.M., December 16, 1957, on the second hospital day.

DISCUSSION

Dr. Robert L. Chancey: First, I wish to dispose of the original hospital admission. From the information presented I find no reason to disagree with the diagnosis of hyperthyroidism, and I do not believe that this illness had any relationship to the final illness and the cause of death.

The second contact with the patient, about one and one-half years prior to death, revealed a moderate hypertension which responded to Rauwolfia. At the time of his final admission to the hospital, his blood pressure was within normal limits.

The cause of death in this patient was obviously a severe gastrointestinal hemorrhage. The origin of bleeding was probably below the level of the stomach since, despite red-black stools, he did not vomit gross blood except as a terminal event. The only suggestive evidence that hematemesis occurred is the statement that he vomited dark fluid two days prior to hospital admission and on one occasion a month previously.

What are the usual causes of massive hemorrhage from the upper gastrointestinal tract? There are two common causes: bleeding peptic ulcer and cirrhosis of the liver with ruptured esophageal varices. It is a recognized fact that painless bleeding peptic ulcer does occur, but it is certainly statistically uncommon. One generally obtains a history of "gas," indigestion, or heartburn, even if there is no actual pain. In addition, if bleeding into the stomach or into the first portion of the duodenum is so severe as to produce red-black stools, hematemesis is to be expected.

There is nothing in the history to suggest cirrhosis of the liver either. There is no history of alcoholism, nutritional deficiency, or previous liver disease. Neither is there anything in the physical examination to arouse suspicion of liver disease, *i.e.*, no jaundice, splenomegaly, ascites, or telangiectasia. In addition, hematemesis is very common when severe bleeding occurs from esophageal varices.

For these reasons I do not believe that the terminal illness was due either to cirrhosis of the liver or to peptic ulceration of the upper gastrointestinal tract.

There are a number of other causes of massive gastrointestinal tract hemorrhage which should be considered in a formal differential diagnosis. Gastritis, in a few large series of reported cases, may cause 10 to 20 per cent of such hemorrhages. Such episodes are ordinarily associated with the ingestion of large amounts of chemical irritants, such as alcohol or aspirin. Hematemesis is an important feature in such cases. I believe that gastritis can be excluded because of the lack of history of such ingestion and the absence of preliminary hematemesis.

Carcinoma of the stomach usually causes sufficient symptoms to warrant investigation prior to any massive hemorrhage. Sudden severe hemorrhage is most unusual as an initial event in gastric tumor, although early bleeding may occur in leiomyoma of the stomach which tends to undergo crater-like ulcerations.

Other less common causes of gastric hemorrhage, such as gastric polyps, gastric diverticula, Osler-Weber-Rendu disease, and uremia, are mentioned only to be excluded.

There are a number of lesions of the small bowel which may produce severe hemorrhage. There are the rare tumors of the small intestine, such as carcinoma, lymphoma, neurofibroma, or benign adenoma. A bleeding Meckel's diverticulum, or duodenal diverticulum, as well as regional enteritis may cause serious hemorrhage. Polyarteritis, various purpuras, and blood dyscrasias may cause bleeding on occasion. I am not intrigued by any of these conditions in this case. Mesenteric thrombosis may lead to massive rectal bleeding, but the condition is usually suspected because of the abdominal pain. Severe abdominal pain was not an important part of this patient's symptomatology.

There is one important finding in this case which suggests the diagnosis. "There was a pulsating mass palpable in the left epigastric region." This offers the strong probability of aneurysm of the abdominal aorta. However, the mere presence of a firm pulsating abdominal mass is not in itself diagnostic, particularly in the hypertensive patient with an elongated aorta in whom the abdominal pulsation may be prominent. An upper abdominal mass produced by a pancreatic or gastric carcinoma may also resemble an aneurysm, although I have excluded this possibility. Rupture of an aortic aneurysm into the bowel is an exceedingly rare cause of massive gastrointestinal tract hemorrhage. In a review of the literature compiled by Hirst and Affeldt[1] in 1951, 43 such cases were accounted for. In an analysis of these cases, males were affected much more frequently than females; pain was commonly an initial symptom and was usually referred through to the back; melena and hematemesis were usually the terminal events. Physical examinations in all but one of eight new cases provided by the authors revealed an abdominal mass which was frequently pulsatile.

This patient's findings and course fit the picture of rupture of an abdominal aneurysm into the intestinal tract. I believe this to be the diagnosis for several reasons: he had a palpable pulsating abdominal mass; the onset was sudden; the stool was red-black, indicating that bleeding came either from the small bowel or very high in the colon, but the massive terminal hematemesis indicates the proximal small bowel; back pain was present; and, the terminal hemorrhage was rapid and severe. As to the site of perforation, I can only speculate. Of the 43 cases mentioned previously, 31 had an aneurysm rupture into the duodenum.

My final diagnosis, therefore, is that an arteriosclerotic aneurysm of the abdominal aorta ruptured into the small bowel, probably the duodenum, with massive fatal gastrointestinal hemorrhage.

Dr. W. H. Pollard: This type of case, admitted with complaints of weakness and reddish-black stools, alerts the clinician to a diagnosis of gastrointestinal hemorrhage. The finding, on physical examination of the abdomen, of a pulsating mass of definite outline, moderately large size, and tender to palpation, is presumptive evidence of an aneurysm of the aorta.

The apparent existance of arteriosclerosis elsewhere in the cardiovascular system, the negative serologic test for syphilis and the occurrence of abdominal or back pain in association with the pulsating mass, are other important factors to further localize the symptoms and signs to the abdominal aorta. Since it is not specifically stated in the protocol, I would like to ask if the pulsation was expansile or merely transmitted.

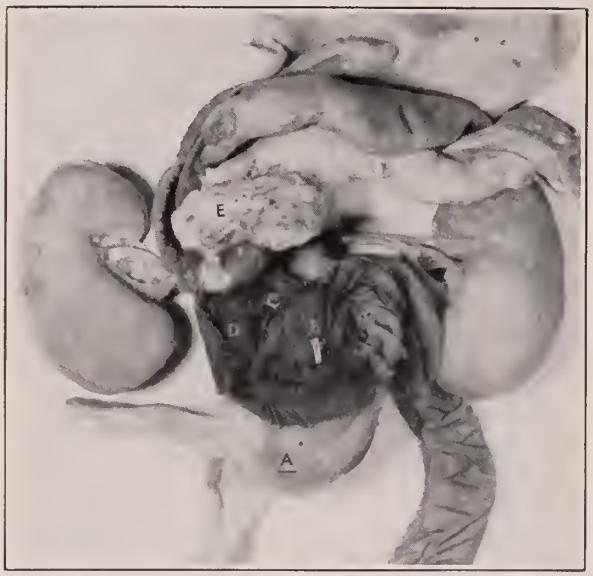

Fig. 1—Rupture of saccular aortic aneurysm, A, into proximal portion of jejunum at site indicated by probe, B. Junction of third portion of duodenum, D, and jejunum indicated by ligament of Treitz, C. Head of pancreas at E.

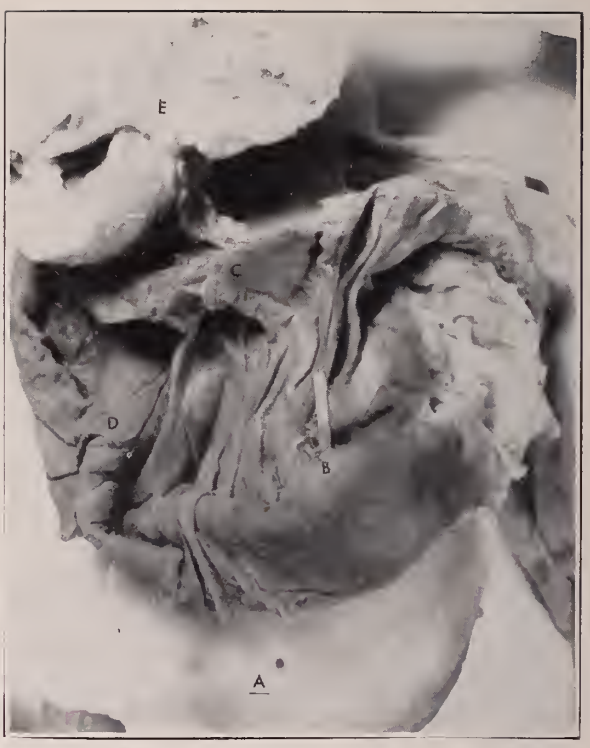

Fig. 2—Close-up view of jejunal rupture site in Fig. 1. A, B, C, D, and E as in Fig. 1.

Doctor Kishpaugh: The mass had a faintly expansible pulsating quality.

Doctor Pollard: Occasionally a tumor or cyst of the pancreas, or even a pendulous left lobe of the liver, may be confused with an aneurysm and may even give the impression of expansile pulsation. In this particular case the correlation between the presenting complaints of melena and weakness to the physical findings of the pulsating mass is at first difficult because of the rare association of aortic aneurysm with gastrointestinal bleeding. Statistics vary widely as to the relative frequency of aortic aneurysms rupturing into the gastrointestinal tract, and I must admit that prior to the discussion of this case, I would not have readily considered this condition as a probable cause of gastrointestinal hemorrhage. However, the few positive physical findings and the sudden dramatic terminus would make that rare condition the likely diagnosis in this case.

AUTOPSY FINDINGS

Dr. E. W. Cauldwell: It is clearly agreed that the diagnosis is one of massive hemorrhage associated with rupture of an abdominal aortic aneurysm into some part of the gastrointestinal tract.

At autopsy, the external features were not remarkable. There was no fluid in the peritoneal cavity, nor was there hemorrhage into the retroperitoneal area. There was purple-red discoloration of the jejunoileum, duodenum and stomach, with marked distention of the stomach. There was a smooth oval mass arising from the retroperitoneal area beneath the proximal portion of the jejunum. The proximal jejunum was firmly adherent to the right anterior aspect of this mass and there was continuity of serosa. The heart exhibited only a mild degree of left ventricular hypertrophy, fibrous thickening of the posterior mitral valve leaflet and moderate coronary arteriosclerosis. The lungs were markedly edematous and moderately congested. The liver, gallbladder, spleen, and pancreas were grossly normal. The stomach was distended with approximately 1,500 ml. of fluid and clotted blood. The pyloric sphincter was large and contracted. The entire duodenum, jejunum and ileum were filled with fluid blood. There was a perforation on the mid-posterior aspect of the proximal jejunum, at a point 1.5 cm. distal to the ligament of Trietz; this perforation measured 8 x 4 mm. (fig. 1 and 2). A probe could be readily inserted through the jejunal perforation into the underlying mass, which was identified as an aneurysm of the abdominal aorta (fig. 3). The aneurysm was of saccular type extending from a point 1 cm. below the renal arteries to the level of bifurcation and included the proximal portion of the left

common iliac artery. The total dimensions of the aneurysm were 10 x 7 x 5½ cm. Although there were abundant atheromatous deposits in the aorta, minimal calcification was encountered, even in the wall of the aneurysm. There was firm attachment between the proximal jejunum and the wall of the aneurysm. The anterior portion of the aneurysm was relatively thin, and at the site of perforation measured only 1 mm. in thickness. There was a massive mural thrombus occupying the lateral and posterior aspect of the sac, and this extended into the orifice of the left common iliac artery with reduction in the diameter of its lumen. There was moderate arteriosclerotic scarring of the kidneys, minimal nodularity of the prostate, and normal urinary bladder, testes, and adrenals. The thyroid was represented by separate lateral lobes weighing 10 gm. each.

On microscopic examination of the site of rupture, there was recent hemorrhage into the jejunal mucosa and submucosa, compression atrophy of the muscularis, and moderately severe lymphocytic infiltration of the adventitia of viscus and aorta.

The anatomic diagnosis in this case is, therefore, rupture of an arteriosclerotic aortic aneurysm into the proximal portion of the jejunum with massive gastrointestinal hemorrhage.

Doctor Pollard, would you care to comment on the possibilities of surgical approach to this problem?

Doctor Pollard: Inasmuch as this condition is basically one of arteriosclerosis, and in view of our rapidly increasing older population, it will probably be seen more frequently. This case, therefore, serves to alert us to one of the extraordinary complications of abdominal aortic aneurysm and provokes us to reappraise our thinking concerning its treatment.

The natural history of the disease is one of deterioration; and so, if surgical mortality can be brought significantly lower than that of the untreated lesion, a basis for therapy can be established.

Methods of treatment of smaller lesions vary from external reinforcement to prevent rupture, either by cellophane or polyethylene sheets with wire reinforcements to endoaneurysmorrhaphy and either arterial homografts or synthetic grafts. From a perusal of the current literature, apparently the reinforcing operations are not satisfactory and

Fig. 3—Dorsal view of aortic aneurysm, A. Site of rupture indicated by probe, B. Left common iliac artery, F, involved by mural thrombus in proximal extent.

the endoaneurysmorrhaphy of Matas is deficient in dealing with the fusiform type of arteriosclerotic aneurysms. Arterial homografts or synthetic grafts, although apparently the best present method of dealing with aneurysms, involve numerous technical factors which may give rise to unpredictable complications. The minutiae of detail in preparing the homografts and the technicalities of resection of the postrenal portion of the aorta with maintenance of viability and physiologic function of various tissues which may be involved in the procedure, of course, present many complex problems, but these problems must be attacked and overcome if this group of patients is to be salvaged. As a matter of fact, successful cases of resection and homograft replacement of thoracoabdominal aortic aneurysms involving the celiac, superior mesenteric and renal arteries have been recently reported by De Bakey and his associates.[2] The medical staffs of our hospitals should be alerted to the frequency of this clinical condition and the potentialities for surgical therapy.

Should operation be delayed until symptoms develop? Should it be denied to the poor risk or the very aged? The ideal case for surgical treatment is the individual in good

physical condition with a large but as yet relatively asymptomatic aneurysm, who can be subjected to a careful evaluation of cardiac and renal function and aortographic study. However, patients with painful or expanding aneurysms need urgent consideration for surgery, since their life expectancy is apt to be short. Patients with leaking aneurysms need emergency surgery with a minimum of investigation. The most helpful radiologic study is the lateral or supine film. The presence of calcium in the wall of the sac is, of course, helpful in demonstrating the presence as well as determining the size of the lesion. The sequence of events in this particular case was so dramatically rapid and complicated by small bowel involvement that our surgical contributions would probably not have altered the course.

Dr. Thomas Sweeney: In this case bleeding was fatal and the laboratory played no decisive role. Bleeding from the gastrointestinal tract usually involves the questions of how much and from where. Ordinarily the clinical laboratory provides a *sequence* of measurements related to blood loss and replacement. The usual procedure is *serial* hematocrits and hemoglobins.

While it would be very desirable to estimate blood volume in these cases with the preferable technique of radioactive chromium[51] or radioiodine bound serum albumin, or even the less valuable Evans Blue procedure, none of these would have contributed much of practical value in this acutely exsanguinating patient.

Shock ensues if 15 per cent of the blood volume is rapidly lost; fatal outcome with 45 per cent uncompensated loss. The essence of treatment in cases of massive gastrointestinal hemorrhage is equally massive supporting transfusions of whole blood. In this case, however, the source of bleeding was from an aortic defect and it would be too overwhelming to permit circulatory compensation. I might just add in passing that the chemical detection of blood in the stool is sensitive to a fault, but generally 2 to 5 ml. are considered the reproducible limits. The tarry stool represents 50 to 80 ml. minimum. When the stomach is palpable and filled with blood it represents about one to one and one-half liters.

Doctor Cauldwell: Aneurysms of the abdominal aorta are becoming more commonly encountered clinically and at autopsy. They have been reported in about 1 per cent of large autopsy series, and represent approximately 20 per cent of all aortic aneurysms. The saccular type occurs more frequently than the fusiform, and these are preponderantly of arteriosclerotic origin. Approximately half of the deaths in cases with abdominal aortic aneurysms result from rupture. The massive hemorrhage following rupture is generally directed into the retroperitoneal tissues; less commonly the initial rupture is into the peritoneal cavity, and only with great rarity into the gastrointestinal tract.

Although rupture of an abdominal aortic aneurysm into the gastrointestinal tract was described by Salmon in 1843, it was not until Rottino[4] presented his collection and review of 31 cases from the literature in 1943, that its clinical importance was realized. I have been able to account for 61 cases of this pathologic association described in published papers up to 1956. The incidence of occurrence of this complicated pathologic process is estimated at about 0.06 per cent of autopsy cases. The third portion of the duodenum was involved in 44 of these 61 cases. This is understandable since these aneurysms are almost always of the saccular variety and perforate into the gut at a site of anatomic fixation. An extensive area of the third portion of the duodenum is in direct relation to the anterior aortic wall, and with expansion of the aneurysmal segment that area would be proportionately increased.

Only 5 cases of aortic aneurysmal rupture into the jejunum are represented in the total of 61 cases. This represents an incidence of 0.005 per cent, or 1 in 20,000, autopsy cases. All of these have been into the proximal portion of the small bowel. In our own case, it can be postulated that the initial attachment was to the adventitia of the distal extent of the third portion of the duodenum in the vicinity of the ligament of Trietz, and as the aneurysm increased in size and extended ventrally and to the left of the midline, there was peeling of the peritoneal investment from the posterior aspect of the proximal jejunum and subsequent adherence to that structure. Further increase in size of the aneurysm resulted in compression atrophy of the jejunal muscularis, chronic inflammation, and subsequent erosion of the fixed bowel wall.

Question: Does hypertension play a role

in the development of these aneurysms and in their subsequent rupture?

Doctor Cauldwell: Hypertension is apparently not an essential factor in the production of the arteriosclerotic aneurysm, since it is present in only about 30 to 35 per cent of reported cases. This patient's mild hypertension had been under adequate therapeutic control for the past one and one-half years. In spite of some interesting teleological speculations, the reason for such localization in the distal aorta is not clear, except that arteriosclerosis does affect this segment of the vascular system frequently and extensively. This does provide localized areas of weakness in the wall which would permit the initial dilatation. In a rigid pipe the pressure rises in a dilated portion and stress on the wall is increased with the greater diameter. According to Blakemore,[5] once an aneurysm has developed, a doubling of the diameter of the tube increases the strain on the sac by 100 per cent. Thus, progressive weakening of the wall continues so that rupture becomes increasingly likely.

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. . . . THE PRESIDENT'S PAGE . . . .

GUNNAR GUNDERSEN, M. D.

THE state of Wisconsin as well as its medical profession is enjoying the rare privilege of having one of its own as president of the American Medical Association. When Dr. Gunnar Gundersen of La Crosse was inaugurated on June 24 in San Francisco a large contingent of his fellow Wisconsin colleagues were there to wish him well and to share in the momentous occasion. Doctor Gundersen is, after all, only the second physician from Wisconsin to have served as president of the American Medical Association during its 111 years.

Doctor Gundersen brings to this high office a fine sense of responsiveness to the needs of the profession and to the people of this nation. He has combined the practice of medicine with a devotion to serve in public health, in organizational affairs of medicine and in the socioeconomic problems related to health.

As a native son of Wisconsin and member of a family of Wisconsin physicians, Doctor Gundersen is a living example of medicine's genius for progress because he, through a work of love and a reward of satisfaction, is making a significant contribution to physicians and to the public.

The feeling of Wisconsin physicians for Doctor Gundersen at this time can probably best be expressed by a statement made by the Council of the State Medical Society in 1953 when he received the Council Award:

> "For your extraordinary influence in the development of better medical care for the people of Wisconsin and the nation, for your devotion to the practice of medicine while at the same time lending much to its scientific and economic development, for your understanding and vision in problems of medical organization and service, and for your zeal to bring about professional regard for the social and economic values in the everyday practice of the healing art . . ."

Doctor Gundersen, your friends and colleagues throughout the state join together in a reaffirmation of their high regard for your contributions and your accomplishments in their interest and in the interest of better health for the people of America.

Jerome W. Forsth

"Wake in our breast the living fires,
The Holy faith that warmed our sires. . . ."
OLIVER WENDELL HOLMES, M. D.

. . . gleanings from the Section on Medical History

Did you ever hear of a doctor who regularly used a handcar to visit his patients?

Most likely not, but in the 1880s, Dr. Thomas B. McIndoe, the first physician in Rhinelander and Oneida County, made and used one to call on his patients living near the lines of two railroads which served the area.

Dr. T. B. McIndoe

It was a velocipede-type handcar, self-propelled, and historians say it logged many, many miles before roads were built in the backwoods. All the lumberjacks and timber crews lived and worked near the railroads, and thus were accessible via the rails.

The State Historical Society archives brought out an account of the time Doctor McIndoe was returning from visiting a patient deep in the timber country when he came upon a 40-car train stalled on the tracks. Knowing he was needed back at his office, he lifted the handcar and toted it—no light task—the full distance. Back on the track, he got his second wind and proceeded to travel to Rhinelander again.

His parents were early settlers in Marathon County, and he was born in 1861. His father died soon after, but the mother, despite many hardships, managed to provide a college education for most of her six children. Doctor McIndoe was graduated from Rush Medical College in 1883, and after one year in Wausau, he moved to Rhinelander. There he practiced for more than 40 years.

Doctor McIndoe shared his office with a brother, the town's first dentist. The community started with a large saw and planing mill, and folks moved in rapidly with exploitation of the area's rich timber resources.

His practice grew in proportion to the rising population, and in time he called in other physicians to share the load.

For many years, Doctor McIndoe served as physician and surgeon for the Soo Line and the Chicago and North Western. He was one of the founders of the Oneida–Vilas–Forest County Medical Society.

His wife died early this year. Doctor McIndoe died in 1929.

* * *

Dr. Thaddeus D. Smith, Neenah, inducted into the "50 Year Club" last May, donated a Seitz tub and an oil painting of the typical family physician. Dr. Smith retired in June.

Four manuscript letters of Dr. N. S. Robinson, one of the first physicians in Neenah, were given to the Society by Mrs. Thaddeus D. Smith. The letters were written in 1858 when Dr. Robinson was looking for a suitable place to practice.

* * *

The State Historical Society reports that citizens of Campbellsport (in Fond du Lac County) are planning to restore or remodel the Dr. Nicholas Senn home in that community, as a historic site. Doctor Senn, who practiced in Ashland and Milwaukee, was president of the A.M.A. in 1897.

* * *

WANTED: Contributions for this page from readers. Or give us suggestions from which to develop articles. Your contributions would assure a continuous flow of material on medical history. Why not take a few minutes' time tonight to jot down one or more of the interesting stories you know, people and places in medical history, events that show early medicine in Wisconsin. Send us early photographs, too, if they are available.

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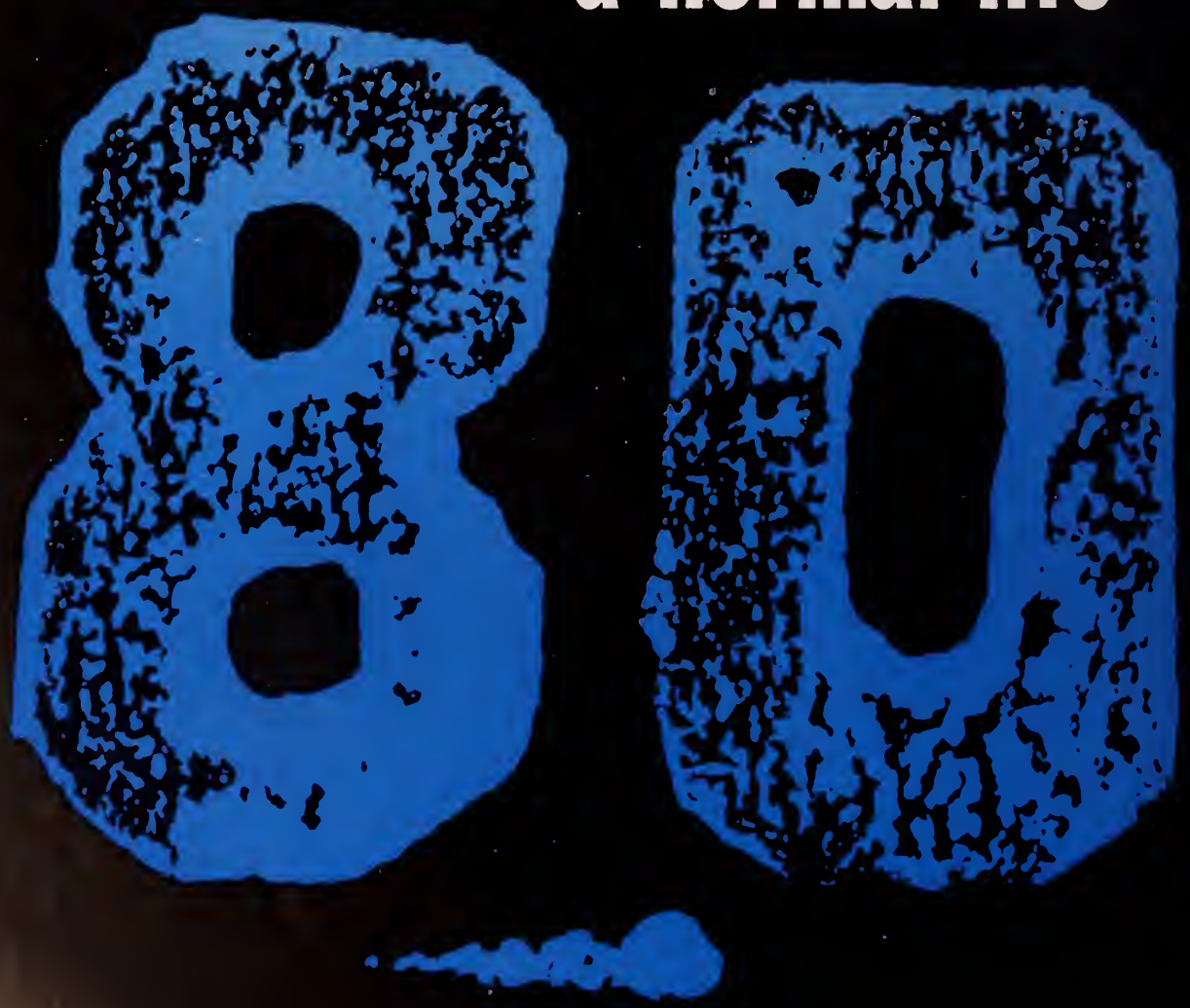

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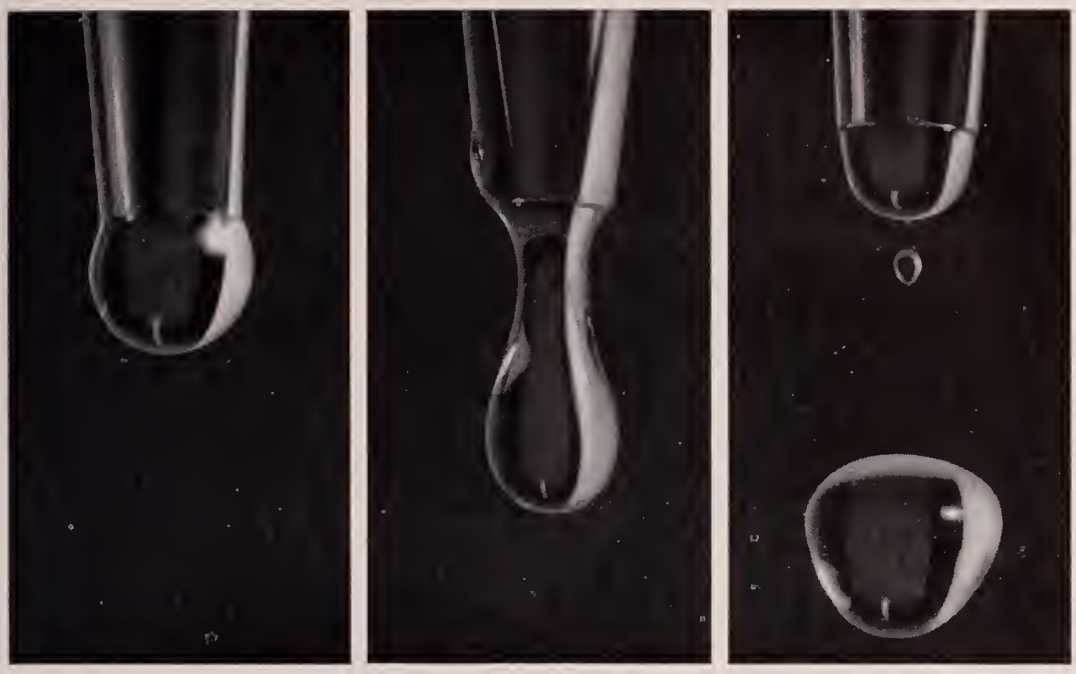

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PUBLISHED REFERENCES: 1. Carpenter, E. B.: Southern Medical Journal 51:627, 1958. 2. Forsyth, H. F.: J.A.M.A. 167:163, 1958. 3. Little, J. M., and Truitt, E. B., Jr.: J. Pharm. & Exper. Therap. 119:161, 1957. 4. Morgan, A. M., Truitt, E. B., Jr., and Little, J. M.: J. Am. Pharm. Assn., Sci. Ed. 46:374, 1957. 5. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:160, 1958. 6. Park, H. W.: J.A.M.A. 167:168, 1958. 7. Truitt, E. B., Jr., and Patterson, R. B., Proc. Soc. Exper. Bio. & Med. 95:422, 1957. 8. Truitt, E. B., Jr., Patterson, R. B., Morgan, A. M., and Little, J. M.: J. Pharm. & Exper. Therap. 119:189, 1957.

Supply: Tablets (white, scored), 0.5 Gm., bottles of 50 and 500.

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Ethical Pharmaceuticals of Merit since 1878

Summary of four new published clinical studies:

Robaxin Beneficial in 95.6% of Cases of Acute Skeletal Muscle Spasm[1, 2, 5, 6]

CONDITION	NO. PATIENTS	RESPONSE			
STUDY 1[1]		"marked"	moderate	slight	none
Skeletal muscle spasm secondary to acute trauma	33	26	6	1	—
STUDY 2[2]		"pronounced"			
Herniated disc	39	25	13	—	1
Ligamentous strains	8	4	4	—	—
Torticollis	3	3	—	—	—
Whiplash injury	3	2	1	—	—
Contusions, fractures, and muscle soreness due to accidents	5	3	2	—	—
STUDY 3[5]		"excellent"			
Herniated disc	8	6	2	—	—
Acute fibromyositis	8	8	—	—	—
Torticollis	1	—	—	1	—
STUDY 4[6]		"significant"			
Pyramidal tract and acute myalgic disorders	30	27	—	2	1
TOTALS	138	104 (75.3%)	28 (20.3%)	4	2

THE JOURNAL
American Medical Association

"In the author's clinical experience, methocarbamol has afforded greater relief of muscle spasm and pain for a longer period of time without undesirable side effects or toxic reactions than any other commonly used relaxants . . ."[2]

THE JOURNAL
American Medical Association

"An excellent result, following methocarbamol administration, was obtained in all patients with acute skeletal muscle spasm."[5]

THE JOURNAL
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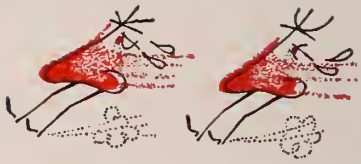
"In no instance was there any significant reduction in voluntary strength or intensity of simple reflexes."[6]

Southern Medical Journal

"This study has demonstrated that methocarbamol (Robaxin) is a superior skeletal muscle relaxant in acute orthopedic conditions."[1]

running noses . . . and other hay fever symptoms



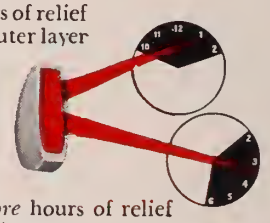
TRIAMINIC stops rhinorrhea, congestion and other distressing symptoms of summer allergies, including hay fever. Running nose, watery eyes and sneezing are best relieved by antihistamine *plus* decongestant action — systemically — with TRIAMINIC.

This new approach frequently succeeds where less complete therapy has failed. It is not enough merely to use histamine antagonists; ideally, therapy must be aimed also at the congestion of the nasal mucosa. Triaminic provides such effective combined therapy in a single timed-release tablet.

TRIAMINIC brings relief in minutes—lasts for hours. Running noses stop, congested noses open—and stay open for 6 to 8 hours.

Triaminic provides around-the-clock freedom from allergic congestion with just one tablet t.i.d. because of the special timed-release design.

first—3 to 4 hours of relief from the outer layer



then—3 to 4 *more* hours of relief from the inner core

Dosage: One tablet in the morning, mid-afternoon and at bedtime. In postnasal drip, one tablet at bedtime is usually sufficient.

Each timed-release TRIAMINIC Tablet contains:

Phenylpropanolamine HCl	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

TRIAMINIC FOR THE PEDIATRIC PATIENT

TRIAMINIC Juvelets*, providing easy-to-swallow half-dosages for the 6- to 12-year-old child, with the timed-release construction for prolonged relief.

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TRIAMINIC Syrup, for those children and adults who prefer a liquid medication. Each 5 ml. teaspoonful is equivalent to ¼ Triaminic Tablet or ½ Triaminic Juvelet.

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- does not impair mental efficiency or physical performance
- relieves both mental and muscular tension
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Sulfamethoxypyridazine Lederle

Unusual Antibacterial and Anti-infective Properties—More soluble in acid urine[1] . . . higher and better sustained plasma levels than any other known and useful antibacterial sulfonamide.[2]

Unprecedented Low Dosage—Less sulfa for the kidney to cope with . . . yet fully effective. A single daily dose of 0.5 to 1.0 Gm. maintains higher plasma levels than 4 to 6 Gm. daily of other sulfonamides—a notable asset in prolonged therapy.[2]

Dosage: The recommended adult dose is 1 Gm. (2 tablets) the first day, followed by 0.5 Gm. (1 tablet) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours.

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Tablets: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

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references:

1 Grieble, H.G., and Jackson, G.G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958

2. Editorial: *New England J. Med.* 258:48-49, 1958.

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Ophthalmic Suspension
prednisolone, 0.5%,
plus sulfacetamide sodium, 10%
Ointment with Neomycin, 0.25%

in blepharitis,
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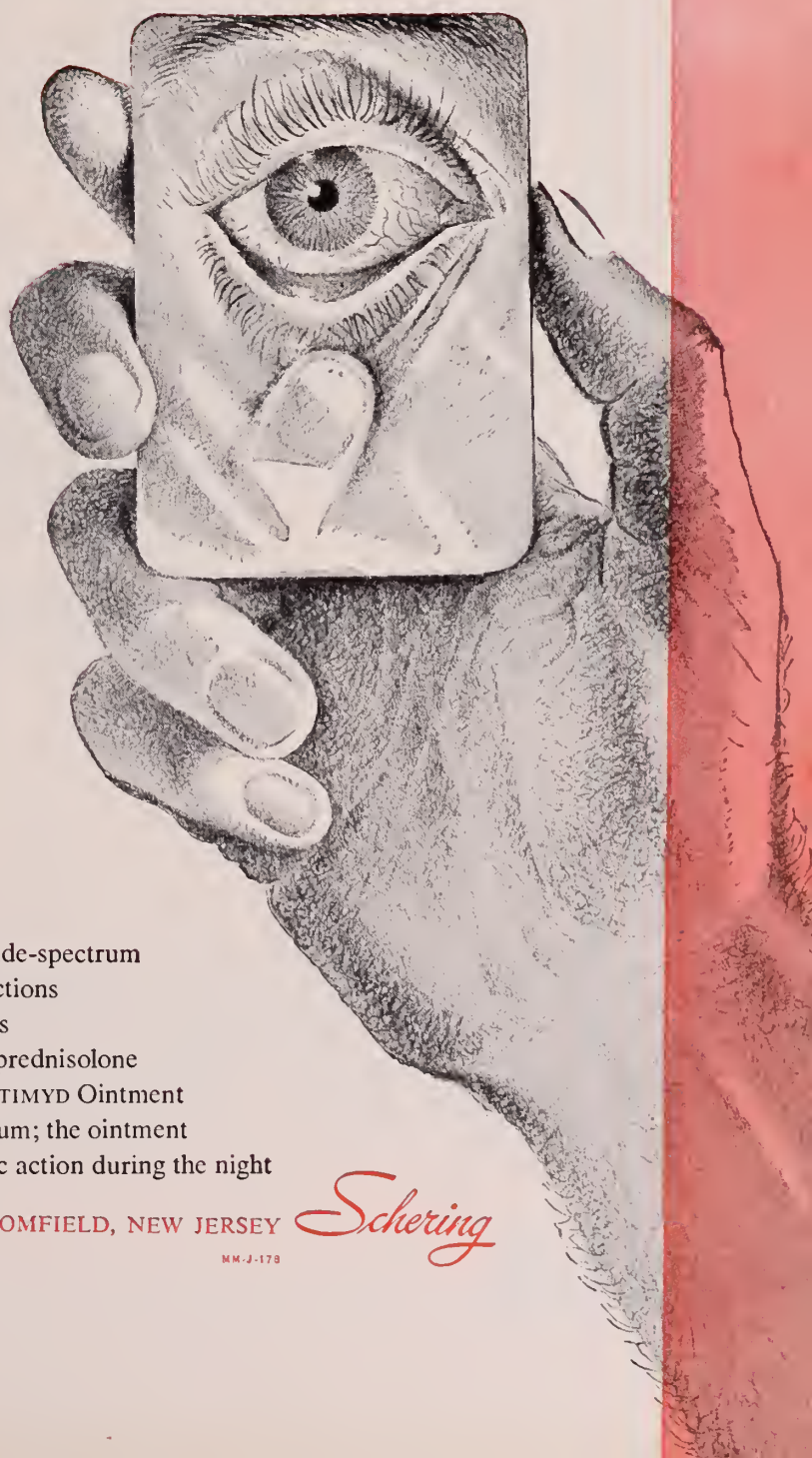
keratitis,
meibomitis
and other
external eye
conditions



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- sulfacetamide sodium, with its wide-spectrum antibacterial range, controls infections caused by common eye pathogens
- addition of neomycin sulfate to prednisolone and sulfacetamide sodium in METIMYD Ointment broadens the antibacterial spectrum; the ointment also assures sustained therapeutic action during the night

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*'Co-Pyronil' (Pyrrobutamine Compound, Lilly)

Prescribe 'Co-Pyronil' in attractive green-and-yellow pulvules for adults; in tiny red pediatric pulvules or tasty suspension for children.

Each Pulvule 'Co-Pyronil' provides:

'Pyronil' (Pyrrobutamine, Lilly)	15 mg.
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'Clopane Hydrochloride' (Cyclopentamine Hydrochloride, Lilly) . . .	12.5 mg.

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Dartal effectively decreases or relieves emotional hyperactivity and psychomotor excitement.

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At a recent symposium, leading hepatologists* concluded that Dartal is not icterogenic or hepatotoxic.

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a superior psychochemical
for the management of both major and minor emotional disturbances

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*A Symposium on the Pharmacologic Effects of Dartal on the Liver, Chicago, Searle Research Laboratories, Feb. 7, 1958.

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why PETN? *For cardiac effect:* PETN is ". . . the most effective drug currently available for prolonged prophylactic treatment of angina pectoris."[1] Prevents about 80% of anginal attacks.

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1. Russek, H. I.: Postgrad. Med. *19*:562 (June) 1956.

Dosage and Supplied: Begin with 1 to 2 yellow CARTRAX "10" tablets (10 mg. PETN plus 10 mg. ATARAX) 3 to 4 times daily. When indicated this may be increased by switching to pink CARTRAX "20" tablets (20 mg. PETN plus 10 mg. ATARAX.) For convenience, write "CARTRAX 10" or "CARTRAX 20." In bottles of 100.

CARTRAX should be taken 30 to 60 minutes *before* meals, on a continuous dosage schedule. Use PETN preparations with caution in glaucoma.

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STATE MEDICAL SOCIETY PRESENTED SILVER TRAY

To commemorate the silver anniversary of the Woman's Auxiliary to the Dane County Medical Society, charter members of the organization this summer presented to the State Medical Society of Wisconsin an English sterling tray.

The tray carries the names of the charter members and these words:

> *"Presented to the State Medical Society of Wisconsin by the Charter Members of the Woman's Auxiliary to the Dane County Medical Society on its Silver Anniversary 1958."*

Mrs. George H. Ewell, Madison, chairman of the gift committee, is shown in the picture above making the presentation to Dr. Nels A. Hill, Madison, third district councilor.

Doctor Hill, in accepting the platter, praised the thoughtfulness of the charter members of the auxiliary society, and said their action exemplified the finest ideals of cooperation between the auxiliary and the State Medical Society.

The following names appear on the tray:

Mrs. Ewell, Mrs. C. W. Aageson, Mrs. Joseph C. Dean, Mrs. James P. Dean, Mrs. Ivan Ellis, Mrs. Eugene M. Juster, Mrs. Edwin F. Schneiders, Mrs. Lester McGary, Mrs. Lindley V. Sprague, Mrs. Roscoe McIntosh, Mrs. Arthur Stehr, Mrs. H. N. Winn, Mrs. William Ganser and the late Mrs. Reginald Jackson.

"Wake in our breast the living fires,
The Holy faith that warmed our sires. . . ."
OLIVER WENDELL HOLMES, M. D.

. . . gleanings from the Section on Medical History

The life story of Dr. Margaret Caldwell, perhaps Wisconsin's first woman physician, was written several years ago for the *Journal of the American Medical Women's Association* by Dr. Elizabeth Comstock of Arcadia.

Doctor Caldwell was born in a log cabin near Pewaukee in 1845, and before she was 16, was teaching in a country school.

Her father thought it would be a good plan for her to marry a neighbor, but she had other plans. She had a cousin who was employed as a nursemaid by a doctor's family in Chicago, so the two girls exchanged places, Margaret going to the big city, and her cousin coming to "wild" Wisconsin to marry the young man.

Inspired to study medicine by her physician–employer, the future Doctor Caldwell entered the Woman's Hospital Medical College, Northwestern University, and was graduated in 1876. She spent two years in Chicago and then settled in Waukesha.

Residents of the area, however, first eyed the lady doctor with unfriendly glances, thinking she should be home doing more womanly work.

She used a horse and buggy on her rounds, sometimes walked, and once in awhile used a Milwaukee Road handcar.

By 1900 she had a private sanitarium and was the physician in charge of Bethesda Spring in Waukesha. Patients from all over the country consulted her.

Doctor Caldwell was an honored member of the Waukesha County Medical Society and served it as president. She wrote and read many papers before the Society. She practiced until 1932, six years before her death.

There's a blue spruce on the hill of the Waukesha Memorial Hospital, planted in her honor 20 years ago by the Florence Nightingale Club.

Assembling the bones of a skeleton more than 100 years old is quite a job, but two University of Wisconsin junior medical students have accomplished the feat.

Several months ago, Dr. Bertha A. Reynolds of Avoca gave the State Medical Society a box of bones. Perhaps, she said, the society's Section on Medical History could find some use for them.

Fred Melms, Milwaukee, and David Ottensmeyer, Superior, volunteered to assemble the skeleton. Both men are employed part time at the State Medical Society.

First they gave the bones, blackened with age, a good scrubbing. When spare time was available, they worked to put the bones together.

"Our classwork consists of working from the skin through the tissue to the body's bonal structure," Melms said. "We must learn the muscles and the bones, of course, but ordinarily, medical students never assemble skeletons. So what we did was unusual. Dave and I learned much."

Ottensmeyer commented; "What we did has been an excellent review of the skeletal system, and definitely improved our general knowledge of the human body."

Doctor Reynolds said the skeleton was once used in the Women's Medical College in Philadelphia. Vandals knocked the skeleton apart and broke the skull. Once a student at the college, she was given permission to gather the parts together and to keep them.

Those who examined the bones, described as those of an elderly female who died before the Civil War, believe she suffered from osteoarthritis.

* * *

Dr. F. X. Pomainville, Wisconsin Rapids, assisted by Dr. R. E. Garrison, made a tape recording on early medical history of Wisconsin Rapids, describing such former practices as mass tonsillectomies and early forcipial deliveries.

Society Proceedings*

Fond du Lac

Thirty-five couples were present at the May 29 meeting of the Fond du Lac County Medical Society to hear *Dr. Edgar End* of Milwaukee speak on "Deep Sea and Skin Diving." The meeting was held at the Republican House in Ripon.

Grant

The Grant County Medical Society met May 29 at the Lancaster Memorial Hospital. Guest speaker was *Dr. William Stovall,* Madison, who addressed the group on the subject of "Carcinoma In Situ Detection, Diagnosis and Treatment." Another Madison physician, *Dr. Fred Ansfield,* discussed recent drugs and treatment of malignant tumors.

The society presented Doctor Stovall with a check of $1,000 as a gift to the medical museum at Prairie du Chien.

* Physicians whose names are printed in italics are members of the Society.

Manitowoc

The main business of the Manitowoc County Medical Society meeting held May 29 at the Hotel Manitowoc was the election of officers for the coming year. Chosen were: *Dr. J. W. Steckbauer,* president; *Dr. R. C. Puestow,* vice-president; and *Dr. D. A. Kuljis,* secretary–treasurer.

Pierce–St. Croix

The June 17 meeting of the Pierce–St. Croix County Medical Society was held in River Falls at the Walvern Hotel. *Dr. R. R. Davis,* New Richmond, talked on civilian defense medical problems in Pierce and St. Croix counties, followed by a discussion on the subject by *Drs. J. O. Grassl,* River Falls, and *C. A. Olson,* Baldwin. Members elected the following officers: *Dr. P. S. Haskins,* president; *Dr. R. R. Davis,* vice-president; and *Dr. P. H. Gutzler,* secretary-treasurer.

During the business meeting a report was given by the chairman of the fee committee, *Dr. G. J. Hopkins.*

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MEDICAL STAFF

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John F. Wyman, M. D.
Hubert H. Blanchard, M. D.
John E. Leach, M. D.
Lloyd F. Jenk, M. D.
Richard O. Barnes, M. D.
John R. Whitty, M. D.

Preston W. Thomas, M. D.

Polk

A joint meeting of the Polk County Medical Society and Woman's Auxiliary was held at Paradise Lodge in Balsam Lake on June 19. The group met for a smorgasbord and to hear Dr. and Mrs. Philip Soucheray talk on the subject, "Seven Times Blessed." A discussion on current health problems in the state was also given by Senator Holger Rasmusen.

Trempealeau–Jackson–Buffalo

On June 24 the Trempealeau–Jackson–Buffalo County Medical Society met at Club Midway in Whitehall. An address was given by *Dr. John Skemp*, La Crosse, on obstetrics and gynecology.

Walworth

The Walworth County Medical Society was host to the Kenosha and Racine County Medical Societies at a meeting held June 18 at the Lake Geneva Country Club. The program included scientific sessions in the morning followed by a buffet luncheon. In the afternoon the group enjoyed golfing, card games, and a boat excursion on Lake Geneva. The day was completed by a dinner and dance.

Winnebago

A social hour and business meeting was held by the Winnebago County Medical Society on June 5 at the Menasha Hotel.

Manitowoc Chapter of American Academy of General Practice

The following officers were elected at the meeting of the Manitowoc Chapter of the American Academy of General Practice held June 10 at Hotel Manitowoc: *Dr. H. E. Schaefer*, Manitowoc, president; *Dr. A. W. Kozelka*, Two Rivers, vice-president; and *Dr. J. E. Nilles*, Mishicot, secretary–treasurer. Also chosen were: *Drs. R. G. Yost, N. A. Bonner* and *C. E. Wall* as delegates; and *Drs. Theodore Teitgen, G. E. Rau* and *Joseph May* as alternates for the state convention.

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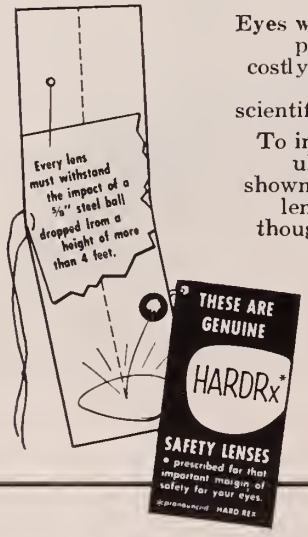

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second restores endocrine balance; relieves vasomotor and metabolic disturbances

third relaxes skeletal muscle; relieves low back pain, tension headache

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Each tablet contains:
Miltown (meprobamate, Wallace) . . . 400 mg.
2-methyl-2-n-propyl-1,3-propanediol dicarbamate
Conjugated Estrogens (equine) . . . . . 0.4 mg.

Supplied: Bottles of 60 tablets.

Dosage: 1 tablet t.i.d. in 21-day courses with one week rest periods; should be adjusted to individual requirements.

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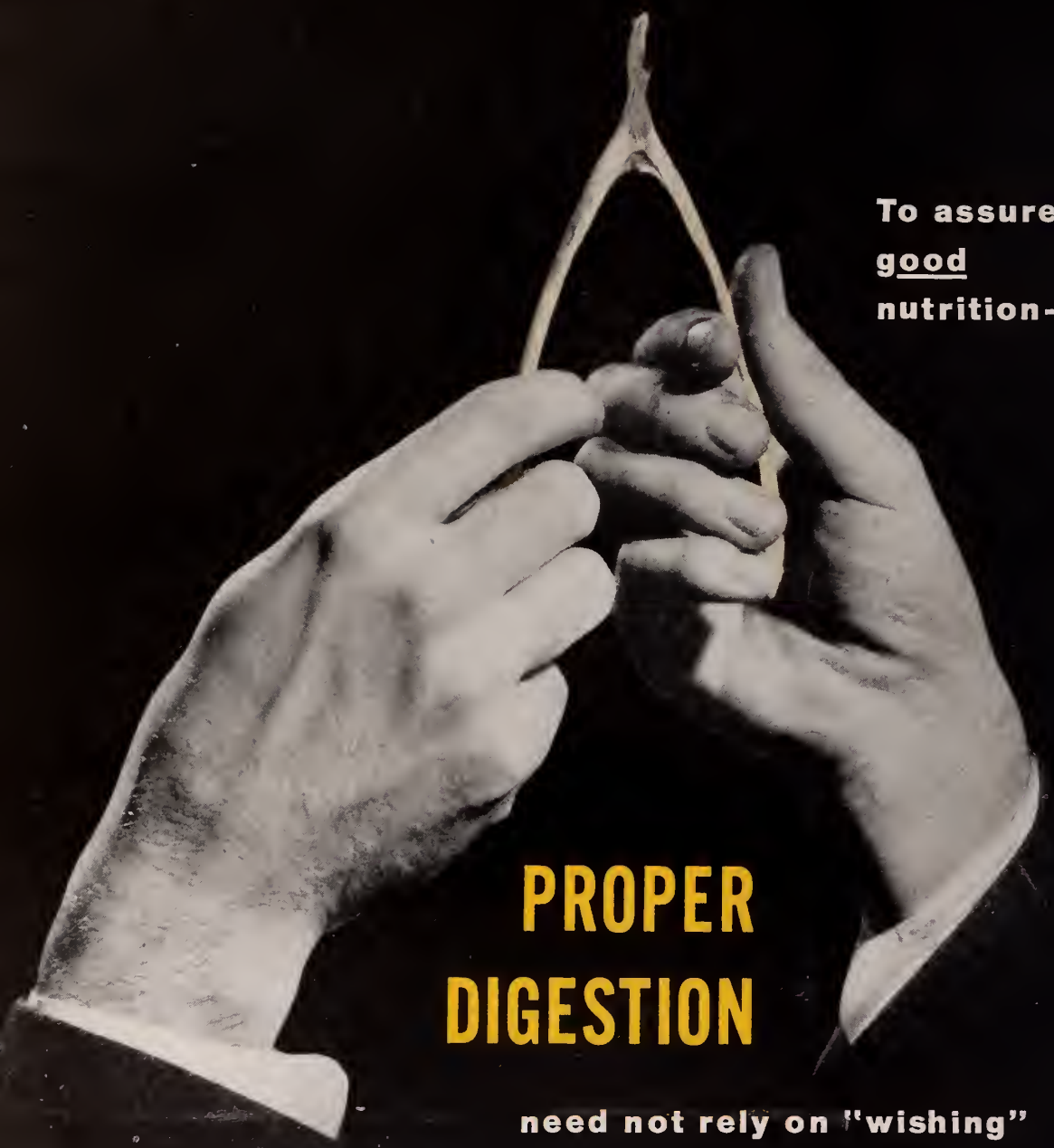

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News Items and Personals*

Doctor Edwards on European Trip

Dr. W. C. Edwards, Richland Center, and his wife sailed on June 11 for a two-month trip abroad. They are touring northern Europe and the Scandinavian countries by car and will visit the families of two American field service students who lived with them while attending high school—one, a boy in northern Sweden, and the other, a girl in Vienna, Austria.

While abroad Doctor Edwards planned to attend the convention of the International Professional Association of Gynecologists and Obstetricians which met July 18 and 19 at Brussels, Belgium.

Hospital Given Equipment in Memory of Doctor

The Lakeland Memorial Hospital, Minocqua, was presented with a Castle portable spotlight for the emergency room and a lightweight Cassette filter screen and corner cutter for the x-ray room. This donation was given in the memory of Dr. Kate Newcomb who passed away May 30, 1956, by the Dr. Kate Newcomb Memorial Foundation, Inc., at Woodruff. During her lifetime, Doctor Newcomb became widely known as an outstanding rural medical practitioner.

Medical Assistants Hear Two Sheboygan County Physicians

Drs. L. J. Steffan, Plymouth, and *J. E. Martineau*, Elkhart Lake, appeared on the program of the fourth annual meeting of the Wisconsin State Medical Assistants Society held at Elkhart Lake, June 7–8. Doctor Steffan spoke on, "Public Health", and Doctor Martineau chose, "Small Town Practice", as the topic of his talk.

Two Rhinelander Doctors Honored

Drs. C. A. Richards and *Irving E. Schiek, Sr.*, who are senior physicians at Rhinelander, were honored for more than 100 years combined of medical service to the Rhinelander area. Certificates were

* Physicians whose names are printed in italics are members of the Society.

Clinical Conference

MISSISSIPPI VALLEY MEDICAL SOCIETY

(The Mid-West's Greatest, Intensive Post-Graduate Medical Assembly)

23rd Annual Meeting

HOTEL MORRISON, CHICAGO, SEPT. 24–25–26, 1958

OVER 40 CLINICAL SPEAKERS

PROGRAM GEARED TO GENERAL PRACTITIONERS AND GENERAL SURGEONS

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MISSISSIPPI VALLEY MEDICAL SOCIETY (Est. 1935)

(Post-Graduate Medical Society of

ILL., IA., KAN., MINN., MO., NEB., N. D., S. D., WIS.)

Harold Swanberg, M.D., Secretary, W.C.U. Bldg., Quincy, Ill.

presented each doctor at an annual banquet of the Rhinelander Chamber of Commerce held June 2 at the Hotel Fenlon. Doctor Richards and Doctor Schiek were lauded for their long years of service to the medical profession and to the people of Rhinelander.

THIRD AND TWELFTH DISTRICTS NEWS

Internal Medicine Seminar Given at UW

A seminar on the "Evaluation of Pulmonary Function" was sponsored by the Wisconsin Society of Internal Medicine at the University of Wisconsin, June 8. Those participating in the study were four University of Wisconsin staff members, Drs. John Rankin, *J. Richard Johnson, Helen Dickie* and *Seymour Crepea;* and two Marquette University members, *Drs. Ross C. Kory* and *O. A. Sander. Dr. J. L. Sims,* Madison, made the arrangements for the meeting.

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Wisconsin Academy of General Practice Meeting September 14–16

The annual scientific assembly of the Wisconsin Academy of General Practice will be held September 14–16 at the Milwaukee Auditorium.

Subjects to be presented include:

Monday, September 15—Diabetes. Orthopedic Knee Injuries. Cause and Prevention of Cystocele and Rectocele. Management of Varicose Veins and Complications. Acute Infections of the Urinary Tract. A Simple Approach to the Problem of Infant Nutrition. Congenital Anomalies—Early Signs and Symptoms. Office Surgery. Putting Science Across for Health.

Tuesday, September 16—Geriatric Problems. Orthopedics. Delivery Room Emergencies. Congestive Heart Failure. Hematuria—Diagnosis and Treatment. Injuries of the Hand. Medical Hypnosis in General Practice.

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A treatment and rehabilitation center providing inpatient and outpatient services for those disabled as a result of neurological disorders.

Diagnostic Studies	Occupational Therapy
Physical Medicine	Vocational Counseling
Speech Therapy	Therapeutic Recreation

Madison Doctor Participates in Scientific Session

An exhibit on, "Segmental Consolidations of the Lung", was presented by *Dr. J. Richard Johnson*, Madison, at the annual meeting of the National Tuberculosis Association in Philadelphia, Pennsylvania, recently. He also participated in a panel discussion of "Sarcoidosis."

New Head of Surgery Department at Marquette

Dr. Carl W. Eberbach, Clinical Professor and Director of the Department of Surgery at Marquette University School of Medicine, relinquished chairmanship of the Department of Surgery to Dr. Edwin H. Ellison, Professor of Surgery at Ohio State University College of Medicine, Columbus. The announcement, made by Fr. Edward J. Drummond, S. J., Academic Vice-President of the University, became effective July 1.

Doctor Eberbach, who since 1950 has been chairman of the Department of Surgery at Marquette until a younger full-time man could be secured, will continue in the teaching program of the medical school and will remain in the private practice of surgery. Doctor Ellison will be a full-time member of the faculty of the medical school. At Milwaukee County Hospital and the Veterans Administration Hospital, Wood, he will be in charge of the educational and research programs in surgery for the medical school. At Milwaukee Children's Hospital Doctor Ellison will asssist and guide the expansion of the undergraduate teaching program in pediatric surgery.

Dr. Ellison is the author of over 50 scientific publications, co-author of the surgical textbook, "*Current Surgical Management*," and recipient of two Cine Clinic awards from the American College of Surgeons for his movies on surgical technique. He is best known for his discovery that intractable peptic ulcers of the stomach and duodenum failing to respond to all types of medical and surgical management not infrequently occur secondarily to a previously unrecognized islet cell tumor of the pancreas. Removal of the tumor results in complete healing of the ulcer.

Mental Health Program Given Grant at U. of W.

The University of Wisconsin School of Education has been awarded a grant of $54,676 in support of a mental health program and has been approved as the recipient of additional funds which total over a quarter of a million dollars for a five-year period.

The award, made through the National Institutes of Health of the Public Health Service, was assigned the University for a "pilot and evaluation project" which will consist of a study of teacher training in student mental health.

Enlarge Animal Quarters at Marquette University

Enlargement of the animal quarters at Marquette University School of Medicine to over twice its present size was begun during July. The projected building program which will be in progress for about 9 to 10 months was made possible through a grant of $118,380 received from the Health Research Facilities Construction Act of the United States Public Health Service. Private matching funds, which are necessary to obtain this grant, are being obtained in part from the estate of the late Dr. L. D. Smith, Assistant Clinical Professor of Orthopedic Surgery, Emeritus, at Marquette, in addition to funds from other private donors who have expressed an interest in the project.

UW Host at Conference for Foreign Scholars

A distinguished visiting faculty drawn from hospitals and medical schools throughout the United States assembled at the University of Wisconsin for the Conference on Medical Education for Foreign Scholars in the Medical Sciences June 30–July 2.

Fifty scholars from 28 countries were in attendance. The conference was sponsored by the UW Medical School and the China Medical Board of New York, Inc., the Association of American Medical Colleges, and the Conference Board of Associated Research Councils.

Members of the UW medical faculty who took part in the conference are *Dean John Z. Bowers* and *Drs. Anthony R. Curreri, Edgar S. Gordon, Ovid O. Meyer, Robert C. Parkin,* and *Robert F. Schilling.*

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These words are quoted from a recent address by Dr. Donald Stubbs of Washington, who currently serves as President of the District of Columbia's Blue Shield Plan and as Chairman of the Board of the national association of Blue Shield Medical Care Plans.

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Third, the Blue Shield idea is the idea of *preserving the private, confidential relationship* between doctor and patient. No "third party" enters into the Blue Shield transaction between doctor and patient. The Blue Shield is the doctor's own mechanism, created in his own image, and dedicated to the sole purpose of helping the doctor the better to serve his patients.

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OBITUARIES

Dr. M. W. Ward, a retired physician, died May 13 at his home in Bangor. He was 80 years of age.

Doctor Ward was born in 1878. He received his bachelor degree at Oshkosh State College and taught school for several years before beginning his medical studies. In 1904 he graduated from Wisconsin College of Physicians and Surgeons. Prior to locating in Bangor he practiced in Norwalk and Arnott.

He was a former member of the State Medical Society of Wisconsin and the La Crosse County Medical Society, having served as president of that society.

One daughter, Helen Wood, Bangor, survives.

Dr. J. C. Betz, 79, died May 20 in Baltimore, Maryland.

An 1899 graduate of Rush Medical College, Doctor Betz was previously located in Boscobel, moving from there 25 years ago to practice in California.

For a number of years he was affiliated with the Grant County Medical Society and the State Medical Society of Wisconsin.

Surviving are his widow and two daughters.

Dr. J. J. Pink, 62, died May 28. He had practiced for 35 years in Milwaukee.

Born in 1896 at Oconomowoc, Doctor Pink graduated from Rush Medical College in 1920. He served an internship at Columbia Hospital in Milwaukee from 1920 to 1922, followed by a year of residency training at Milwaukee Children's Hospital. In 1922 Doctor Pink established an office in Milwaukee for the practice of internal medicine. He served on the medical staffs of Columbia and Milwaukee Hospitals.

Memberships held by Doctor Pink included those with the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, the American Medical Association, the Wisconsin and Milwaukee Societies of Internal Medicine, the Milwaukee Academy of Medicine and the Eastern District Appeal Board of Selective Service for the State of Wisconsin. In 1942, he was president of the Milwaukee Academy of Medicine; was secretary of the Milwaukee Society of Internal Medicine from 1942–44.

Immediate survivors include his widow, Ruth; and two children, Mrs. Patricia Brown and John J., III, both of Milwaukee.

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Dr. Stephen Cahana, retired Milwaukee specialist in internal medicine, passed away June 1 at age of 76.

He was born in Rumania in 1881 and came to the United States when a child. In 1911 he graduated from the University of Illinois School of Medicine and interned in Chicago Norwegian American Hospital. In addition to his Milwaukee practice, Doctor Cahana served on the State Board of Health for 28 years, having held the office of president; was chief physician of the Milwaukee fire department; and was on the Marquette University faculty, being associate clinical professor of medicine emeritus since 1948.

Dr. Stephen Cahana

When Doctor Cahana retired in 1954, a testimonial dinner was given at Madison in his honor. At that time he received a certificate of public service from Governor Kohler and a silver plaque from the State Medical Society in recognition of his work. In September, 1957, Doctor Cahana was the recipient of a certificate of appreciation for his many years of devoted service and constant support and encouragement of Marquette University's aims and ideals. This certificate was presented at a testimonial dinner in his honor at Marquette University. Since his retirement he had spent his winters in California and it was there that he died.

An honorary member of the State Medical Society of Wisconsin, Doctor Cahana was also a member of the Medical Society of Milwaukee County and the American Medical Association.

Besides his widow, Irma, two daughters, Mrs. Leonard Borok of Chicago and Mrs. Nicholas Ricci of Milwaukee, survive.

Dr. M. C. Dishmaker, a Milwaukee physician, passed away June 3 at the age of 54. As a result of ill health he had retired from practice five years ago.

Doctor Dishmaker was born at Carlton in 1903. He received his medical education at Rush Medical College, graduating in 1926. During the next two years he interned at St. Mary's Hospital, Milwaukee, and took a residency at Milwaukee Children's Hospital. Upon the completion of his training, Doctor Dishmaker began practice at Milwaukee.

He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his widow, Viola; his mother and a brother.

Dr. M. E. Gabor of Milwaukee succumbed June 6 after a short illness. He was 63 years of age.

A native of Czechoslovakia, Doctor Gabor was born at Frastak in 1894. He graduated from Karl Fridriech University, Czechoslovakia, in 1919 and took an internship and residency in Vienna. During World War I he served in the Austrian Army. Doctor Gabor came to this country in 1927 and located in Milwaukee, opening an office for the practice of gastroenterology and internal medicine.

Doctor Gabor was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, the American Medical Association, the Milwaukee Academy of Medicine, and the Milwaukee Chapter of the National Gastroenterological Society.

He is survived by his widow, Barbara; a daughter, Mrs. R. L. Christiansen; and a son, John, all of Milwaukee.

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THE MEDICAL FORUM

CALL SPECIAL MEETING OF HOUSE OF DELEGATES

WASHINGTON, D.C.—A breakfast get-together with Dr. Gunnar Gundersen, La Crosse, newly-installed president of the A. M. A., was arranged by the Wisconsin Congressional delegation in July.

Sen. Wiley (R-Chippewa Falls) commented:

"Dr. Gundersen made a very fine statement, and the delegation felt prouder than ever that he represents our state in the high, new role which is his."

The meeting was held soon after the new A. M. A. president took office at the annual meeting in San Francisco.

With Dr. Gundersen in the picture above were (front row, seated): Rep. John Byrnes (R-Green Bay); Dr. William J. Kennard, of the Washington office of the A. M. A.; Sen. Wiley; Dr. Gundersen; Rep. Gardner Withrow (R-La Crosse) and Sen. William Proxmire (D-Madison). Standing, Rep. Don Tewes (R-Waukesha); Rep. William Van Pelt (R-Fond du Lac); Frank W. Kuehl, of the Washington office of the A. M. A.; Rep. Lester Johnson (D-Black River Falls); Rep. Melvin Laird (R-Marshfield); Rep. Clement Zablocki (D-Milwaukee); Rep. Alvin O'Konski (R-Mercer); Rep. Henry Reuss (D-Milwaukee) and Drs. Cyrus Maxwell and Joseph Davis, of the Washington office of the A. M. A.

MADISON—A special session of the House of Delegates has been called by the Council of the State Medical Society to provide complete information and study of the philosophy and policies of prepaid medical care programs in Wisconsin.

The meeting is to be held within approximately eight weeks from the time of the Council meeting at Land O' Lakes on July 25–26. The session is to be held in a location outside of Milwaukee or Madison, if at all possible.

AGREEMENT VIOLATED

The action was taken after lengthy consideration by the Council of the problems created when the Medical Society of Milwaukee County violated its gentlemen's agreement with the State Medical Society concerning territorial limitations on the sale of Blue Shield. The violation of the agreement came when the Milwaukee County Board of Directors joined with Blue Cross in annexing 10 counties adjacent to Milwaukee for the sale of Surgical Care, its Blue Shield plan. By agreement, since 1947, Surgical Care had been limited basically to sale within Milwaukee County.

The Council also declared that, in view of the violation of the gentlemen's agreement, the State Medical Society is authorized to sell sickness insurance in the entire state through Wisconsin Physicians Service.

W. P. S. APPROVED

Wisconsin Physicians Service is the only Blue Shield plan approved by the State Medical Society for sale in the entire state, the Council declared.

Since May 26, when the agreement was broken by Milwaukee County, the Milwaukee Blue Shield Plan has been extended not only to the 10 counties, but to all sections of the state.

Full details of the developments to date will be provided for members and delegates prior to the special session.

S.M.S. TO STUDY NEW N.F.I.P. MED CARE PLAN

MADISON—The recently announced research and medical care programs of the National Foundation of Infantile Paralysis will be studied by the State Medical Society to assure uniform handling of direct medical care projects according to acceptable medical principles.

The Foundation recently announced extension of its research fund raising and medical care programs into certain problems involving arthritis, diseases of the central nervous system and birth defects. Patient care is proposed for childhood arthritis, and for children through 18 suffering from certain birth defects involving the central nervous system. Within certain limitations, hospital care, case finding and screening, outpatient care, home care and rehabilitation are proposed. In some areas, travel teams may serve children with these conditions.

The Council acted to assure desirable standards for these programs in Wisconsin. The project will be handled by the Commission on Medical Care Plans of the Society.

The Council also authorized a call for copies of the constitution and bylaws from each county medical society for purposes of review and modernization. Approval was given to a resolution submitted by the Wisconsin Society of Pathology providing that all laboratories using cytological technique for diagnosis of diseases be under the actual control of doctors of medicine and preferably specialists in pathology or clinical pathology.

Dr. E. H. Pawsat

DR. PAWSAT NAMED TO PRESIDENT'S YOUTH COMMITTEE

WASHINGTON, D.C.—Dr. E. H. Pawsat, Fond du Lac, Wis., has been named to President Eisenhower's Committee on the Fitness of American Youth.

Dr. Pawsat is a former chairman of the State Medical Society of Wisconsin's Division on School Health.

Established by federal order in late 1957, the committee seeks to coordinate means to improve the fitness of young people, and to stimulate efforts in their behalf.

NEW POLICY ON MEDICARE DRUGS

MADISON—Oral medication dispensed or prescribed by a physician to Medicare patients receiving obstetrical care no longer is reimbursable under the federal program.

Officials of the military dependents' medical care plan said physicians may continue to bill Medicare for cost of drugs administered parenterally in cases where drugs are related directly to the condition for which authorized care and treatment are provided.

INFORMATION NEEDED

In order to obtain reimbursement, the doctor should include the name of the drug, quantity and cost on the claim form he submits to the State Medical Society office.

This ruling does not affect the supplying of drugs on an inpatient hospital basis.

Medicare patients may continue to obtain medication from service facilities upon their physicians' prescriptions or through civilian pharmacies at their own expense.

KENOSHA HITS "PLAY" GUNS

KENOSHA — Police recently launched a fight against the sale of peashooters, slingshots and BB guns to youngsters in Kenosha.

The cooperation of merchants was requested by Lt. Beulah Hartwig, who also asked parents to conform with a city ordinance which bans the "sale of guns, pistols, revolvers or any other dangerous or deadly weapon to any minor or intoxicated person."

The police department considers the guns dangerous in the hands of children, and the businessmen were asked to keep these articles off their counters.

"In the past," Lt. Hartwig said, "some of our youngsters have been seriously injured in playful activity with these weapons."

PENALTIES LISTED

Failure to observe the ordinance can result in a fine of $100 or a 30-day county jail sentence.

The local action is a followup of a strong protest initiated last year by the State Medical Society's Division on Visual and Hearing Defects against the use of dart shooting pistols, some of which also shoot pellets and BBs. Commonly advertised as children's "toys," the guns have caused numerous accidents and represent a special hazard to the eyes.

The division's study, which showed that the guns shoot accurately and with penetrating force at distance up to 30 feet, resulted in a resolution adopted by the society's Commission on State Departments. It was widely publicized.

Medicare Payments $31,076 in June

MADISON—Wisconsin Medicare payments in June totalled $31,076, bringing the amount paid out for 6,974 claims in 1958 to $483,922. The program for payment of medical care for dependents of military personnel began in December, 1956.

Payments in May this year totalled $37,598.

The total amount paid for claims filed through the State Medical Society office for Wisconsin, Minnesota, Iowa, North and South Dakota and Indiana was $189,946. The total for the first half of 1958 was $2,189,575, based on 29,857 claims.

Dr. H. A. Sincock

Elect Dr. Sincock To Hospital Group

MADISON—Dr. H. A. Sincock, Superior, has been elected chairman of the State Advisory Hospital Council.

The council also recommended that the Wisconsin State Board of Health adopt a proposed Wisconsin State Plan for Hospitals and Medical Facilities covering the 1958–1959 fiscal period. This will be submitted to the surgeon general of the U. S. Public Health Service for approval.

Wisconsin Physician Sparks Air Safety

MADISON—A Wisconsin physician–flier is apparently succeeding in his efforts to improve airline safety through better health and medical care of the nation's pilots.

Six months ago at the Philadelphia A.M.A. meeting, Dr. L. O. Simenstad, Osceola, as an alternate delegate to the A.M.A., introduced a resolution urging the association to seek establishment of a completely adequate and competent medical department within the Civil Aeronautics Administration. He charged that some of the nation's airline pilots were being given physical examinations by chiropractors and that the C.A.A. medical department was virtually non-existent.

The A.M.A. adopted his resolution and at once appealed to Congress to secure the enactment of appropriate legislation. It is insisting that physical standards for and medical evaluation of pilots must be carried out by physicians experienced in aviation medicine.

PHYSICIAN REALIZES DREAM—BOATS DOWN MISSISSIPPI

Putt-Putts Down Flooded Waters In Outboard

WISCONSIN RAPIDS—A Wisconsin Rapids physician and a lawyer companion realized a dream of many years this spring—they floated down the Mississippi in a sturdy 16-foot outboard.

Dr. Leland C. Pomainville and Atty. Richard Brazeau, Wisconsin Rapids, traveled more than 800 miles on the swift, flood-swelled river aboard the "Maggie Lee," propelled by a 50 hp motor. The route covered the Ohio and Mississippi from Paducah, Ky., to Vicksburg, Miss.

"We were the first boat down the big river this spring," Atty. Brazeau said. "After seeing the lazy Wisconsin river, we never realized the magnitude and devastating force of the Mississippi until we saw it."

The pair, putt-putting along, made approximately 160 miles a day, pulling into shore each night. They rode the crest of high water created by heavy rains in the Ohio valley.

"We had no thought of possible flood waters when we started," Dr. Pomainville said. "We encountered waters up to 34 feet at Memphis and 27 at Vicksburg.

"But that danger wasn't our only handicap. The unexpected turbulence became so strong with whirlpools and eddys as big as our house that we had to quit at Vicksburg. From there to New Orleans we rode piggy back on a big boat being delivered by Sturgeon Bay navigators."

LOTS OF RAIN

Their boat was equipped with nine 50-gallon gasoline tanks, a spare motor, oars, life jackets, anchors and plenty of clothes, weighing a total of 2000 pounds.

It was lucky they brought rain gear because they motored through four hours of rain on the second day of the five-day trip.

The first day flowed smoothly. From Paducah, the "Maggie Lee" breezed down the high Ohio, past Cairo, Ill., into the big Mississippi. The stop that night was at Carruthersville, Mo. Strong winds and rains and a stubborn current made things troublesome the next day. A considerable amount of floating debris poured into the father of waters from smaller streams.

DR. L. C. POMAINVILLE is shown above at the wheel of the "Maggie Lee," the boat that carried him and Atty. Richard Brazeau down the Ohio and Mississippi rivers this past spring. The background is the shoreline near Cairo, Ill.

"We never quite knew what to expect," Dr. Pomainville said. "Sometimes we held near the shoreline and other times we headed for the center. We had to lower our canvas top and ride in the rain because we were afraid the boat would upset in the turbulence.

"The farther south we went, the more wild the current. The second night was spent in Memphis, the third in Helena, Ark, and the fourth in Vicksburg."

Most impressive, the voyagers said, were the friendly folks along the river. Several went out of their way, driving over muddy roads as much as 15 miles, to help them buy gasoline. Also of interest was the surprising amount of river traffic, with huge barges setting up a strong wake which added to Dr. Pomainville and Atty. Brazeau's job of navigation.

The men were aided by 57 charts, provided by the U. S. Army Corps of Engineers in St. Louis, and by marked mile posts on the river channel.

After reaching New Orleans, they used the "Maggie Lee" to tour the bayous and Lake Ponchartrain, and were much impressed with the natural beauty of the area.

"We had three close calls," Dr. Pomainville related. "The first was in a storm when a barge was bearing down on us and we ran out of gas in one tank. But the motor didn't fail and we kept right on going.

"Another harrowing experience was when we almost ran into a barge cable, head high. The third incident was when we crossed New Orleans harbor in front of an ocean liner and hit a plank floating in the water. Again the motor rose to the occasion."

Would they do it again?

"We had the time of our lives," the men agreed. "It was a fabulous adventure, one which we'd like to do all over again sometime. We'd advise a trip like this for complete relaxation to all tired and overworked colleagues."

Dr. Pomainville is Region 12 chairman for the National Boating Association, a non-profit corporation of, by and for American boatmen. Region 12 includes Wisconsin, Iowa, Illinois and Missouri.

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MILWAUKEE WISCONSIN

27 PHYSICIANS ENTERED IN PRIMARY CORONER RACES

Primary Sept. 9; General Nov. 4

MADISON—Twenty-seven physicians are known candidates for the office of coroner in elections scheduled this fall. Races will be held in all counties except Milwaukee, with the primary balloting Sept. 9, and the general election Nov. 4.

Two chiropractors also are in the race, having registered in Trempealeau and Wood counties.

Six of the candidates are farmers; three others are retired and three are hospital employees. There are two each of the following:

Laborer, salesman, mechanic, real estate agent, newspaper employee and ambulance service.

The list includes one each of the following occupations:

Junk yard manager, cattle dealer, chicken hatchery operator, homemaker, fuel oil salesman, restaurant operator, maintenance man, optometrist, anesthetist, physiotherapist, former police investigator, store clerk, mill worker, radio–appliance dealer, policeman, accountant, furniture dealer, gasoline station operator, contractor, insurance claims manager, x-ray technician, former policeman, electrician, bonding service manager, unemployed.

The occupations of 30 others were not specified by the county clerks replying to questionnaires sent out by the State Medical Society. Price and Marquette counties have no candidates this year.

For some years, the State Medical Society has encouraged its members to seek the office of coroner, holding that its duties require the exacting services of a doctor of medicine. At the same time, the society has advocated legislation to permit appointment of medical examiners, as in Milwaukee County.

Names, hometowns and occupations of candidates, when available, follow:

Adams County — **Arthur R. Weihe, M.D., Adams.**

Ashland—Marius Berg, Ashland.

Barron — Dean F. **Hammond, M.D., Barron.**

Bayfield — Clarence A. Zanto, Washburn.

Brown — C. M. Belisle, Green Bay, optometrist; Ray O. Hussang, Green Bay.

Buffalo—**Emmett A. Meili, M.D., Cochrane.**

Burnett—**R. L. Hartzell, M.D., Grantsburg.**

Calumet — LeRoy A. Hughes, Menasha, physiotherapist; Richard F. P. Olson, Chilton, anesthetist.

Chippewa — **Earl A. Hatleberg, M.D., Chippewa Falls.**

Clark—Robert F. Lulloff, Neillsville.

Columbia — Kenneth W. Reuhl, Portage.

Crawford—Dave Meyer, Prairie du Chien, junk yard manager; Bernard R. Watson, Gays Mills, merchant, and Robert W. Armstrong, Prairie du Chien, retired postal employee.

Dane—Michael Malloy, Madison, former police investigator; Patrick H. Martin, Madison, insurance claims manager.

Dodge—**Harold J. Heath, M.D., Juneau.**

Door—Calmer A. Nelson, Sturgeon Bay, retired.

Douglas — **Edward G. Stack, M.D., Superior;** Arthur Smith, Superior.

Dunn—R. W. Hildebrandt and Martin Krogstad.

Eau Claire — **George W. Beebe, M.D., Eau Claire;** Louis E. Severson, Eau Claire.

Florence — John Nau, Florence, laborer; Harold S. Peters, Florence, school building engineer.

Fond du Lac—Frank H. Decker, Fond du Lac, salesman; Frank J. Kluza, North Fond du Lac, salesman; Nic. P. Spallas, Fond du Lac, store clerk.

Forest—Earl Brownell, Crandon, mechanic.

Grant—J. Dallas Wepking, Lancaster.

Green—**William E. Hein, M.D., Brodhead;** Wilbur Deininger, Monroe, accountant.

Green Lake—**G. G. Mueller, M.D., Princeton.**

Iowa—**W. D. Hamlin, M.D., Mineral Point.**

Iron—K. H. Backlund and John M. Da Ronco, Hurley.

Jackson — **John Noble, M.D., Black River Falls.**

Jefferson—Ewald J. Reichert, Ft. Atkinson, hospital employee; Gilbert Werner, Watertown.

Juneau—J. A. Buchert, Elroy, farmer; Martha D. Swenson, Wonewoc, homemaker, and C. R. Swanson, New Lisbon, city assessor–maintenance man.

Kewaunee — Victor Cherovsky, Kewaunee, gas station operator; Robert Weidner, Kewaunee, chicken hatchery operator.

Kenosha—W. R. Carroll, R. J. Wavro, M. H. Simonson and C. Heeck, Kenosha.

Lafayette—Richard Barth, Darlington, farmer; Gerald Keene, Shullsburg, unemployed disabled veteran.

Langlade—Frank Shebuski, Antigo, disabled policeman; Harry Gibbons, Antigo, newspaper employee.

Lincoln — **William E. Braun, M.D., Merrill.**

Manitowoc—**Theodore A. Teitgen, M.D., Manitowoc.**

Marathon — Herbert Lambert, Edgar, radio–appliance dealer.

Marinette—Edward L. O'Hearon, Marinette; Dewey Lemay, Marinette.

Marquette—No candidates.

Monroe—Jack D. Brown, Sparta.

Oconto—Clarence McMahon, Gillett, farmer; Alvin Exferd, Oconto, laborer.

Oneida—Robert Gironimi, x-ray technician and Richard Brusoe, policeman, Rhinelander.

Outagamie—Bernard H. Kemps, Appleton, linotype operator; A. G. Gerhardt, Appleton, electrician.

Ozaukee—**John F. Walsh, M.D., Port Washington.**

Pepin—**R. J. Bryant, M.D., Durand.**

Pierce—**A. Russell Aanes, M.D., Ellsworth.**

Polk — **L. O. Simenstad, M.D., Osceola;** Neal P. Reynolds, Amery, garageman.

Portage — Joseph Bodzislaw, Stevens Point, mill worker.

Price—No candidates.

Racine — Bernard Evenson, Racine, bonding service manager; Edward Peil, Racine, retired.

Richland — **Dayton H. Hinke, M.D., Richland Center.**

Rusk — Robert Larson, Ladysmith, hospital employee; Fred Conover, Bruce, contractor; Raymond Besseler, Hawkins.

(Continued on page 42)

Dr. C. G. Reznichek

Name Madison M.D. To C–D Committee

MADISON— Dr. C. G. Reznichek, Madison, has been named to a six-member task force to organize medical personnel as part of a commission on national emergency medical care.

A program against thermonuclear attack is being developed by the A. M. A. under contract from the Federal Civil Defense Administration, which is providing nearly $150,000 to complete the project by late 1958.

The commission is expected to recommend the planning, training and operational organization needed for the treatment and care of casualties and others prior to, during and after a hypothetical attack upon a selected geographical area in this country.

It has been asked to make recommendations for the use of professional and non-professional personnel of the medical and related professions and outline the basic role and emergency responsibilities of the medical profession in the immediate pre-attack and post-attack period.

It is anticipated that the emergency care plan will be available and helpful to state and county medical societies in planning civil defense measures.

PRAISE F.D.A.

SAN FRANCISCO—The Federal Food and Drug Administration was commended by the A.M.A. for its "untiring efforts in behalf of the public and the medical profession in protecting them from objectionable and harmful practices in the production and sale of foods, drugs, medical devices and cosmetics."

The action came at the annual meeting of the A.M.A. in June.

SPECIAL!

CHICAGO—The principles of Medical Ethics and Opinions and Reports of the A. M. A. Judicial Council, abstracted and annotated, were published in a special June 7 edition of the J. A. M. A.

For the first time in the association's history, opinions and reports of the council interpreting the Principles of Medical Ethics were assembled and made available to all members. Several sections of the 1955 edition of the principles also were included.

Dr. F. J. L. Blasingame, general A. M. A. manager, said it was deemed advisable to take this action to preserve the language used in the past to express ethical concepts. It serves also, he said, to emphasize that the short (1957) version of the principles does contain the spirit and intent of previous, longer versions.

"I am sure," Dr. Blasingame said, "this document will be valuable to all physicians and especially to those whose duties include serving on boards of censors or similar committees. I hope every physician will become familiar with the contents of this document and preserve it for future reference."

A.M.E.F. REPORTS CONTRIBUTIONS

CHICAGO—The American Medical Education Foundation recently reported it had received contributions from Dr. Gunnar Gundersen, La Crosse; Mrs. George G. Stebbins, Madison; Mrs. B. F. Eckardt, Sheboygan, and from the Benjamin Franklin school in Milwaukee.

Forecast Med Needs in 1970

WASHINGTON, D. C.—A medical research effort of contemplated magnitude would require an increase in the number of physicians and others engaged in such research from 20,000 to 45,000 by 1970.

That was the conclusion drawn by a group of special consultants to Secretary of Health, Education and Welfare Marion B. Folsom.

The consultants said expenditures for medical research in this country can and should be tripled to reach a billion dollars in the next 12 years. Funds for construction of medical schools will be needed, they said, "on a much larger scale than heretofore contemplated.

"Even if large funds are provided, it seems certain that the number of physicians (now 132) per 100,000 population will decline during the next 12 years."

The consultants added:

"This expansion required in the national interest will be costly and should not be restricted by lack of funds. Medical schools cannot now turn out enough doctors to meet the growing medical care needs of the expanding population and to provide sufficient staff for a research program of the scale we propose. Fourteen to 20 new schools are needed; this will cost between $500,000,000 and $1,000,000,000.

It was suggested that the federal government continue to provide about 50 per cent of all funds for medical research. On this basis, federal expenditures would climb from $186,000,000 last year to $500,000,000 in 1970.

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A.M.A. WITNESSES BEFORE HOUSE COMMITTEE ATTACK NEW S-S BILL

WASHINGTON, D. C.—The medical provisions of H.R. 9467 are unwise, unnecessary and not in the public interest, Dr. Leonard Larson, Bismarck, N. D., told the House Ways and Means Committee recently.

Representing the A.M.A., he appeared at a hearing on proposed amendments to the Social Security Act. These proposals would authorize service benefits in the form of hospitalization and surgical care for the retired and survivor beneficiaries under Title II of the S–S Act.

"This would mean a federally financed and federally controlled system of medical and hospital care, first for the beneficiaries, subsequently for other groups and ultimately for everyone," Dr. Larson told the committee.

"No one knows what this proposed program would cost. It is our best estimate that initially it would run about two billion dollars per year. What it would cost eventually cannot be estimated. But we do know historically that the cost of programs such as this one is invariably much higher than the amount initially predicted for them—witness the financial plight of socialized medicine in England.

"This tremendous and unpredictable drain on the S–S trust fund could seriously jeopardize the actuarial soundness of the entire program. The retirement funds of millions of Americans would be endangered through the launching of a program of this type at a time when the system, for the first time in history, is receiving less income than is being paid out.

"The members of the medical profession, as citizens and physicians, look with suspicion and fear upon legislation such as H.R. 9467 which would stifle and destroy the energetic and imaginative free-enterprise medical programs now in progress. A proposal which would legislate the aged into a permanent state of dependency and most important one that would propel us completely and irresponsibly into a federally controlled health care program.

"It is evident that federal intervention is not required."

Dr. Frank H. Krusen, Rochester, Minn., who followed Dr. Larson, said the medical profession has not in the past and is not now taking a position of opposition to the over-all S–S program. The new proposals, however, he said, "represent a major and dangerous deviation from the original concept of the system."

He continued:

"This legislation would inevitably result in poorer—not better—health care for the intended beneficiaries. We know that the aged do not need short stays in general hospitals but rather improved home and community care as well as less costly and improved chronic illness and nursing home facilities.

"The most serious aspect of this legislation is that it is National Compulsory Health Insurance all over again. Under it, the federal government would finance the health care of from 12 to 13 million citizens through earmarked compulsory taxes; the government would control the disbursement of funds; the government would determine the benefits to be provided; the government would set the rates of compensation for hospitals, nursing homes and physicians; the government would audit and control the records of hospitals, nursing homes and patients; and the government would promulgate and enforce standards of hospital and medical care."

The professional relationship between the doctor and his patient would be hampered, Dr. Krusen said, adding that the hospitalization provisions of the bill would create a needless and dangerous over-crowding of already limited facilities.

"In other countries where similar legislation is in effect," he said, "there has been a staggering increase in the use of hospital facilities by the aged.

"The bill says in effect that the aged cannot obtain voluntary health insurance protection. This is not factual, since more than 40 per cent of them now have some form of such insurance. This shows the problem is being solved by the health insurance industry.

(Continued on page 42)

WHEN FILING MEDICARE FORMS . . .

MADISON—Because of omissions, a significant number of Medicare claim forms filed by physicians must be returned.

The State Medical Society said it often is necessary to return blanks to physicians for additional information. The Washington Medicare office will not accept claim forms which are incomplete.

Most commonly omitted items are:

1. The physician has not checked the appropriate box and provided his signature in item 29 of the claim form.
2. The patient's Medicare authorization card number is not provided.
3. The obstetrical patient does not sign the certification called for in item 24 of the form.
4. The sponsor's service number required in item 12 is omitted.
5. The patient's age is not indicated in item 2.
6. The physician fails to provide certification of the care of a consultant in item 31.
7. **The dates of treatment are not shown in item 18.**

If office staff members will check these items carefully, it will reduce repetitive handling between the state Medicare office and the office of the physician, and expedite payment.

Seek Better Draft Law

SAN FRANCISCO—A more equitable call up of physicians in time of a national emergency will be sought by the American Medical Association through contacts with the Department of Defense.

The Iowa delegation to the June A.M.A. meeting proposed the action in view of the expiration of the basic selective service act on June 30, 1959. It urged continuation of some special provisions to apply to physicians but requested that in the event of an emergency all eligible physicians with no prior service should be called before recall of those with prior service except for members of the ready reserve.

OUTLINE GROWTH OF WISCONSIN TUBERCULOSIS CONTROL

Aid, Care and Patient-Load Show Progress

MADISON — The story of 50 years of tuberculosis control in Wisconsin was traced by Dr. Milton Feig of the State Board of Health in an article which appeared in *Wisconsin Counties*, official publication of the Wisconsin County Boards Association.

Dr. Feig said the prompt reporting of cases and deaths to public health departments is essential to the control and eradication of tuberculosis. In Wisconsin, such reporting began in the 1890's, although it wasn't until 1905 that tuberculosis cases became legally reportable in cities of the first to fourth classes and 1907 that tuberculosis was declared a statewide reportable disease.

LOW REPORT TOTAL

The 1908 annual report of the board lists 2,431 tuberculosis deaths, but only 973 cases were reported! The death rate that year was 238 per 100,000 population and the case rate about one per 1,000. In October, 1908, the Wisconsin Anti-Tuberculosis Association was organized.

His summary continued:

Prior to 1913, public health nurses active in tuberculosis control were employed by the Visiting Nurses Association, American Red Cross and the W. A. T. A. The passage of a state "enabling" act for the employment of county nurses occurred in 1913, followed in 1914 by the hiring of the first nurse (her salary was paid by Christmas seal sales) to carry on a county-wide TB program.

The W. A. T. A. established a course of training for public health nurses in 1916 and, after a demonstration program it sponsored, the first county appropriation of funds was made for a nurse in Chippewa County. Cities were enabled to employ such nurses by legislation passed in 1917. However, a 1919 law to make employment of county nurses mandatory was repealed in 1923. The legislature allowed $1,000 state aid to counties with public health nurses by 1935 legislation.

SANATORIA

Sanatoria, important in the history of tuberculosis control, began to open in 1907—the Wisconsin State Sanatorium at Wales and the private River Pines Cottage Sanatorium near Stevens Point. Permissive legislation for establishment of county sanatoria was passed in 1911 and broadened in 1913.

Dr. Milton Feig

Some county sanatorium firsts are the establishment of temporary quarters in Milwaukee County in 1911, permanent quarters in Manitowoc County in 1913, founding of a sanatorium for tubercular mental patients in Douglas County in 1914, the first closing of a sanatorium in 1946 in Waukesha and Washington counties, the first sanatorium to operate as a joint county home in Sheboygan County in 1955, and the first sanatorium to operate as a joint county hospital in Racine County in 1956.

FACILITIES DECLINE

During 1957, there were 1,576 tuberculosis beds available in the state—in 15 county institutions, two private sanatoria and one state sanatorium. However, the legislature closed the Wisconsin State Sanatorium Dec. 31, 1957. The number of patient days of occupancy decreased from 767,298 in 1942 to 412,944 in 1957.

Since May, 1945, any person who is a legal resident or who has lived in Wisconsin five years is entitled to free care when he enters a tuberculosis sanatorium. State aid for county patients has been provided since 1911; from 1949 to 1953, and since 1955, there has also been state aid for TB outpatient clinics.

CASE FINDING

The prevalence of tuberculosis may be determined by a consideration of the following items:

(1) The Wisconsin case rate in 1956 was 42.9 per 100,000 as opposed to 54.5 in 1910, and

(2) The case-finding rate by the mobile unit survey was the same in 1956 as in 1950—0.6 per 1000 small x-rays.

Screening procedures used have been tuberculin testing, mobile unit x-rays and routine general hospital admission x-rays. The W. A. T. A., State Board of Health and the State Medical Society all strongly advocate routine tuberculin testing programs for low-incidence groups.

Mobile unit programs, initiated in 1941 by the W. A. T. A. and the board, now x-ray about 290,000 persons in the state each year. Hospital admission x-rays, begun in 1946 at Wisconsin General Hospital (Madison) with equipment loaned by the board, numbered 35,719 in 1956. During 1956, 2,117 cases were followed up as a result of screening procedures.

Since 1941, the board's tuberculosis register system has operated at state, district and local levels. To date, about 27,000 persons with reported tuberculosis have been registered in these files.

REHABILITATION

A chapter in Wisconsin tuberculosis history closed on Dec. 31, 1957, when the only full-time rehabilitation facility in the state—the Lake Tomahawk State Camp—was abolished by the legislature. It had been operating since 1915 and had treated approximately 2,250 patients.

NEW CODE GETS GREEN LIGHT

SAN FRANCISCO—A national interprofessional code for physicians and attorneys was adopted by the A.M.A. House of Delegates here in June.

The new code was adopted in part from the interprofessional code between the State Medical Society of Wisconsin and the Wisconsin Bar Association in 1955. The new A.M.A. code will be presented for approval of the House of Delegates of the American Bar Association later this year.

CORONER RACE . . .

(Continued from page 38)

Rock — Richard McCaul, Beloit, real estate agent.

Sauk—**O. V. Pawlisch, M.D., Reedsburg**; C. V. Dohner, Reedsburg.

Shawano—Caryle Hofman, Shawano; Harvey C. Stubenvoll, Shawano.

Sheboygan — **Reed M. Simpson, M.D., Sheboygan**; R. F. Grandlic, Sheboygan, ambulance service.

St. Croix—**A. W. Limberg, M.D., Glenwood City.**

Taylor — Frank Perkins, Medford.

Trempealeau—James E. Garaghan, Whitehall, real estate agent; Paul Tushar, Arcadia, *chiropractor.*

Vilas—Edward Stallman, Eagle River, furniture dealer.

Vernon—**Robert A. Starr, M.D., Viroqua**; Otto E. Borrison, Viroqua, farmer; Tom Rogers, Hillsboro, farmer.

Walworth—Osmund L. Bakkom, Zenda, farmer.

Washington—**James E. Albrecht, M.D., Jackson.**

Waukesha — James E. Welch, Eagle, cattle dealer; Charles Cotter, Waukesha, fuel oil salesman.

Waupaca — **Sam Salan, M.D., Waupaca**; Edward J. Schnell, Clintonville, restaurant operator.

Waushara — **Russell C. Darby, M.D., Wautoma.**

Winnebago — **George A. Steele, M.D., Oshkosh**; Arthur C. Miller, Oshkosh, ambulance service; Robert Jung, Oshkosh, hospital attendant.

Wood—**Louis Pfeiffer, M.D., Nekoosa**; Robert J. Bittner, Wisconsin Rapids, *chiropractor.*

Ask MDs to Push Jenkins–Keogh Bills

SAN FRANCISCO—Strong endorsement of the principle of the Jenkins–Keogh plans was again given by the House of Delegates of the A.M.A. meeting here in June.

The Jenkins–Keogh bills provide that self-employed persons in the United States might establish their own retirement programs with proper tax deferments similar to those already granted to employed individuals.

PHOTOGRAPHY CONTEST!

MADISON—Announcing—the Wisconsin Doctor's Photography Contest!

The State Medical Society's Charitable, Educational and Scientific Foundation will sponsor the show of pictures, to stimulate interest in the varied activities of the medical profession.

Wisconsin physicians are urged to mount, in accordance with rules below, pictures they have already taken, or start taking pictures they would like to enter in the show.

All members of the society are eligible to compete by submitting pictures in the following classes:

Class A—"Physicians at Work"
Class B—"Physicians in Research and Teaching"
Class C—"Physicians and History"
Class D—"Physicians in Public Service"
Class E—"Physicians at Play"

Entries will be received at the society office after February 15, 1959. The pictures will be displayed at the annual meeting of the society in Milwaukee next May. Prizes will be awarded at the annual dinner.

General contest rules:

There shall be no entry fee, and no limit on the number of entries by one doctor.

All pictures must be mounted on white mounting boards, 16 by 20 inches only. Boards will be exhibited in a vertical position.

Prints may be black and white, or color. Color prints will not be separated from black-white entries, nor will color influence the judging which will be based solely on content and composition.

Prints may be of any size up to 16 by 20 inches, if verticals; 11 by 14 inches if horizontals.

Prints may be placed singly on the mounting boards, or in series. Series will be judged on the same basis as single pictures. Series must have a minimum of three pictures, maximum of eight. Limit of four boards per series, and these must be hinged in back with tape or adhesive material.

All pictures must carry this information on the back of mounting boards: picture titles, class in which entered, names and addresses of persons entering the pictures. There shall be no writing or printing on the front of the mounting board or on any picture.

All pictures become the property of the State Medical Society.

All pictures must be taken by the entrant, but developing, enlarging and mounting need not be done by him.

The judges reserve the right to change the category if it is ruled that a picture is not entered in its proper class. If not sufficient (10) entries are received for one class, the pictures must be reclassified.

The foundation may later use these pictures for historical purposes, for use in society publications, or for education and public relations purposes.

A.M.A. WITNESSES . . .

(Continued from page 40)

"H.R. 9467 would destroy the voluntary health insurance business among the aged and could eventually, we feel, destroy the entire voluntary private health insurance movement, which now covers 123 million Americans.

"Basically, the problem of the aged calls for aggressive leadership at the family and community level. . . Greater use of Hill–Burton funds could do much. The A.M.A. has a new committee (the Joint Council to Improve the Health Care of the Aged) which is taking a positive, optimistic approach as it explores the entire spectrum of problems relating to the aged."

But no one, Dr. Krusen declared, "has at this time sufficient information on the health needs of the aged on which to base authoritatively a drastic, far-reaching proposal such as H.R. 9467."

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FINNERTY, F. A., Buchholz, J. H. and Tuckman, J.: J.A.M.A. **166**:141, Jan. 11, 1958.

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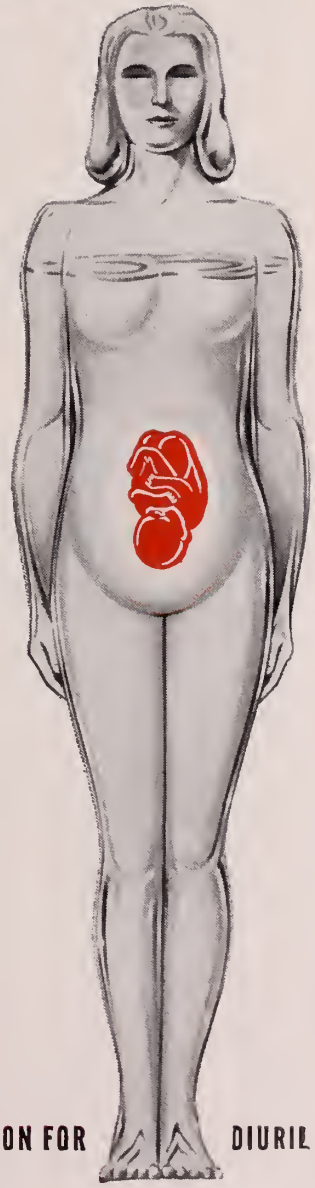
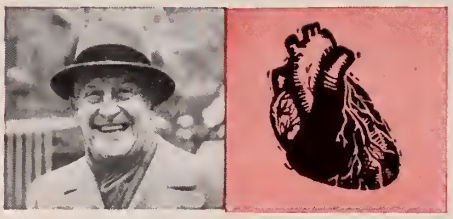


ANY INDICATION FOR DIURESIS IS AN INDICATION FOR DIURIL

in each of these indications for a tranquilizer...



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SURGERY—Surgical Technic, Two Weeks, September 15, September 29
Surgery of Colon and Rectum, One Week, September 23, October 27
Basic Principles in General Surgery, Two Weeks, October 13
Gallbladder Surgery, Three Days, November 3
Surgery of Hernia, Three Days, November 6
General Surgery, Two Weeks, November 10; One Week, October 27
Fractures & Traumatic Surgery, Two Weeks, October 20
American Board Review Course, Two Weeks, November 10
Blood Vessel Surgery, One Week, October 20
GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, Two Weeks, September 8
Vaginal Approach to Pelvic Surgery, One Week, October 6
General & Surgical Obstetrics, Two Weeks, September 22
MEDICINE—General Review Course, Two Weeks, October 20
Electrocardiography, Two-Week Basic Course, October 6
Gastroscopy & Gastroenterology, Two Weeks, November 3
American Board Review Course, One Week, September 29 (For Part I Candidates Only)
DERMATOLOGY—Clinical & Didactic Course, Two Weeks, November 3
UROLOGY—Two-Week Intensive Course, October 13
Ten-Day Practical Course in Cystoscopy by appointment
RADIOLOGY—Diagnostic X-Ray, Two Weeks, September 22
Clinical Uses of Radioisotopes, Two Weeks, September 29

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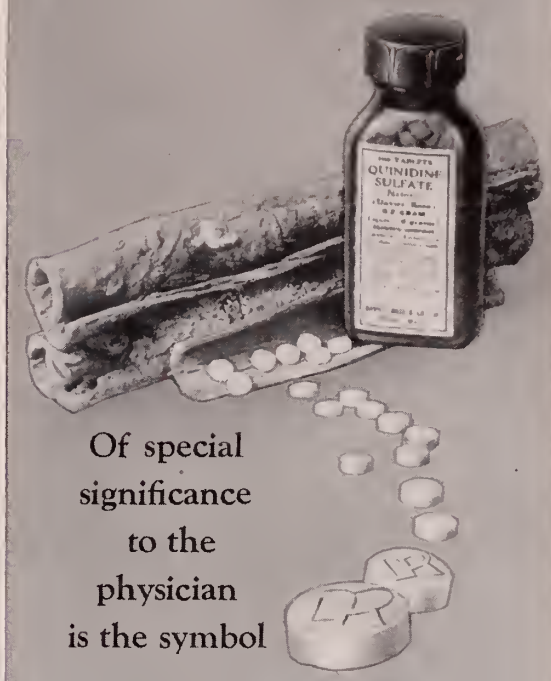

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- in pregnancy when vomiting is persistent
- following neurosurgical diagnostic procedures
- in infections, intra-abdominal disease, and carcinomatosis
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The New York Academy of Medicine will hold its Second Annual Postgradute Week (formerly the Graduate Fortnight), from October 13 to 17, 1958, inclusive. As last year, the title of the program is "Research Contributions to Clinical Practice." The program will consist of daily evening lectures, a daily afternoon panel meeting and a Scientific Exhibit.

Registration, without fee, will be required for non-Fellows of the Academy. All physicians, including interns and residents, and those working in the allied sciences, are invited to attend all sessions.

PROGRAM

MONDAY, OCTOBER 13

Panel Meeting—3:30 P.M.

The Diagnosis and Management of Cerebral Vascular Diseases.

Chairman: Irving S. Wright, Cornell University Medical College.

Lectures—8:30 P.M.

Studies of Contractile Proteins of Muscle.

Andrew G. Szent-Gyorgyi, Institute for Muscle Research.

The Metabolism of the Erythrocyte.

Irving M. London, Albert Einstein College of Medicine, Yeshiva University.

Studies of the Le Cell and the Le Factors.

Henry G. Kunkel, The Rockefeller Institute for Medical Research.

TUESDAY, OCTOBER 14

Panel Meeting—3:30 P.M.

Influenza and Upper Respiratory Infections.

Chairman: Walsh McDermott, Cornell University Medical College.

Lectures—8:30 P.M.

Heriditary Aspects of Disease.

Barton Childs, The Johns Hopkins University School of Medicine.

Congenital Diseases of Blood Proteins.

Charles A. Janeway, Harvard Medical School.

Hereditary Diseases of Connective Tissue.

Victor A. McKusick, The Johns Hopkins University School of Medicine.

WEDNESDAY, OCTOBER 15

Panel Meeting—3:30 P.M.

Glomerulonephritis and Pyelonephritis.

Chairman: William Goldring, New York University College of Medicine.

Lectures—8:30 P.M.

Some Mechanisms of Bactericidal Chemotherapeutic Action.

Bernard D. Davis, Harvard Medical School.

Observations on the Nature of Staphylococcal Infections.

David E. Rogers, Cornell University Medical College.

The Control of Staphylococcal Sepsis.

Carl W. Walter, Harvard Medical School.

THURSDAY, OCTOBER 16

Panel Meeting—3:30 P.M.

Potassium Therapy.

Chairman: Saul J. Farber, New York University College of Medicine.

Hepatic Circulatory Physiology.

Stanley E. Bradley, College of Physicians and Surgeons, Columbia University.

Jaundice and Bilirubin Metabolism.

Rudi Schmid, Harvard Medical School.

Management of Portal Hypertension.

Arthur B. Voorhees, Jr., College of Physicians and Surgeons, Columbia University.

FRIDAY, OCTOBER 17

Panel Meeting—3:30 P.M.

The Radiation Hazard.

Chairman: J. E. Rall, National Institutes of Health.

Lectures—8:30 P.M.

The Fate of Sodium and Water in the Renal Tubules.

Homer W. Smith, Sc.D., New York University College of Medicine.

Mechanisms of Renal Tubular Transport.

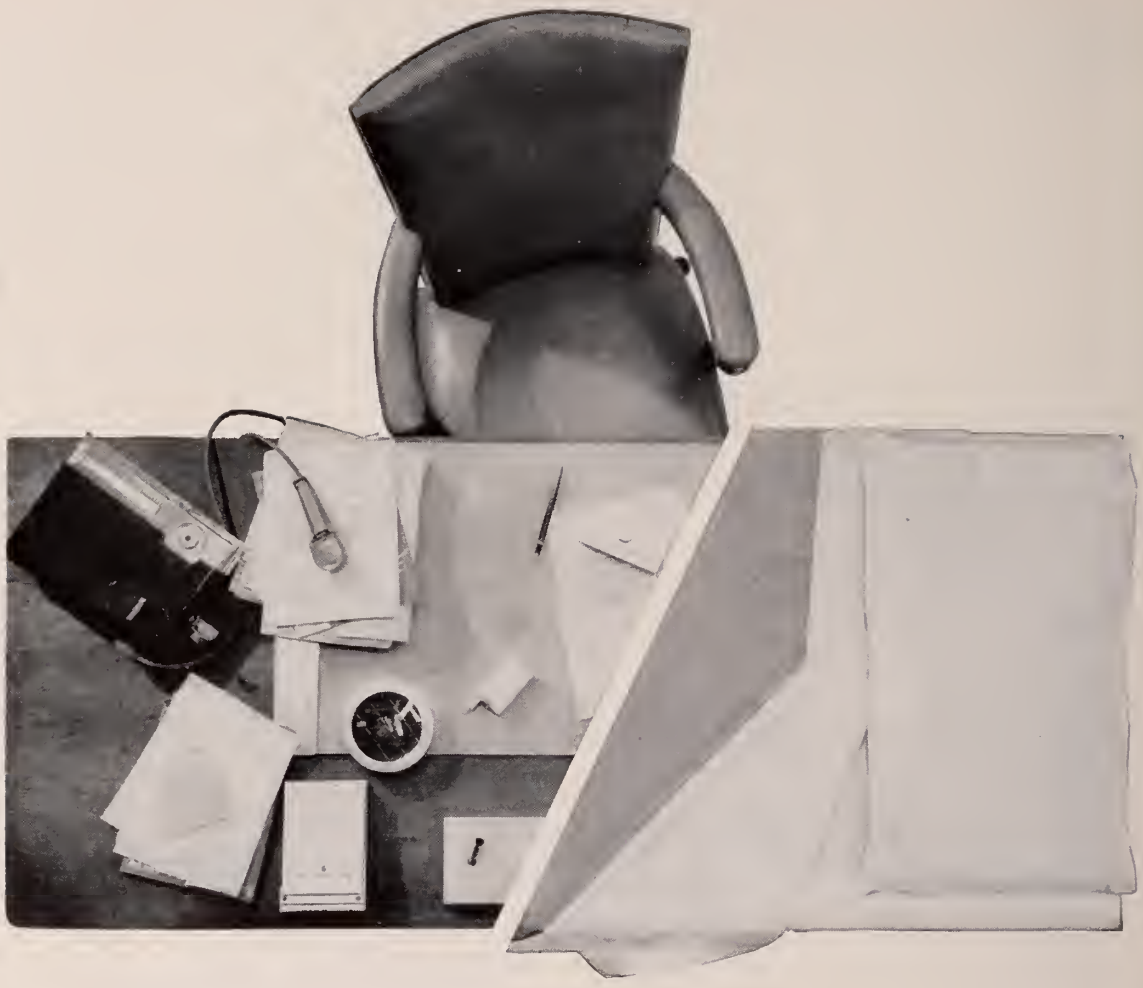
John V. Taggart, College of Physicians and Surgeons, Columbia University.

Electron Microscopy of the Kidney in Normal and Diseased States.

Johannes A. G. Rhodin, New York University College of Medicine.

* * *

All inquiries should be addressed to: Secretary, Postgraduate Week, The New York Academy of Medicine, 2 East 103 Street, New York 29, N. Y.



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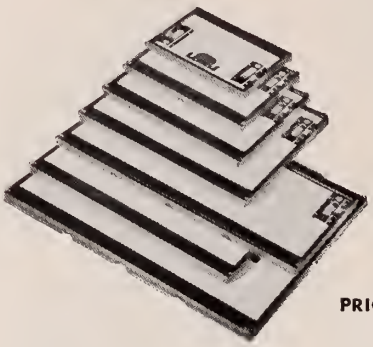

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E. A. Herbert, Green Bay, to Overlook Drive, Willimantic, Connecticut.

L. F. Jermain, Milwaukee, to Medical Center, University of Indiana, c/o Department of Hematology, Indianapolis, Indiana.

P. A. Leuther, Hillsboro, to 272 East Nassau Street, Lake City, Florida.

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HYPNOSIS SOCIETY ANNUAL MEETING, OCTOBER 29–31

The Society for Clinical and Experimental Hypnosis, an International Scientific Society, comprised of physicians, dentists and psychologists engaged in the clinical use of hypnosis, will present a scientific program in Chicago at the Morrison Hotel, October 29 to 31, 1958.

The program will include breakfast seminars, round-table luncheons, panel discussions and formal presentations.

The medical program will include such topics as: hypnotherapeutic control of habit patterns (drug addiction, smoking, overweight), hypnosis in physical therapy and rehabilitation, hypnosis in asthma and allergic manifestations, use and abuse of hypnosis in general practice, hypnosis in pediatrics and geriatrics, hypnosis in minor and major surgery, hypnosis in internal medicine, hypnoanesthesia in obstetrics, physiology of hypnosis, hypnosis in psychiatry.

Immediately preceding the annual meeting of the Society, the Institute for Research in Hypnosis of the Long Island University Postgraduate School will present its annual workshop in clinical hypnosis, October 27 to 29, at the Morrison Hotel.

Registration for breakfast seminars, round-table luncheons and general sessions will be limited. For a copy of the program and more detailed information, write to the Administrative Secretary, Society for Clinical and Experimental Hypnosis, 750 N. Michigan Avenue, Chicago 11, Illinois.

AMERICAN COLLEGE OF PHYSICIANS SEPTEMBER MEETING IN MILWAUKEE

The Midwest Regional Meeting of the American College of Physicians will be held in Milwaukee September 27 at the Milwaukee County Hospital.

There are about 1,000 members in the states of Illinois, Indiana, Iowa, Minnesota and Wisconsin.

A scientific program of 21 papers of 15 minutes each has been arranged.

A luncheon at noon, banquet and entertainment in the evening as well as a luncheon and entertainment at noon for the ladies is on the schedule.

A cordial invitation is extended to all physicians, members of the College and non-members. There is no registration fee.

Joseph W. Rastetter, M. D., F.A.C.P., of Milwaukee is general chairman. Frederick W. Madison, M. D., F.A.C.P., of Milwaukee is governor of the American College of Physicians for the state of Wisconsin.

Interim Meeting of the American Institute of Ultrasonics in Medicine

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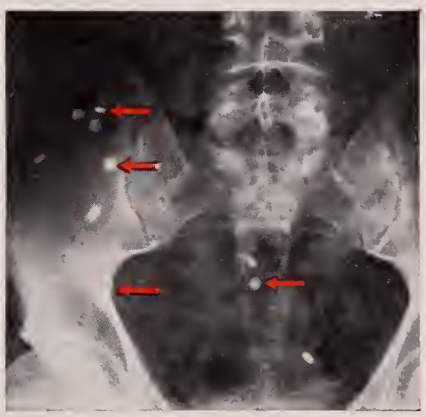

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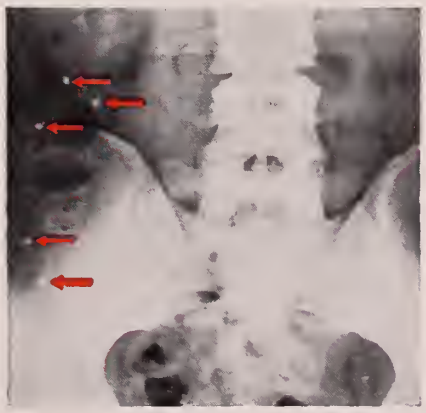

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ASSOCIATION WANTED: General practitioner, 36, married, family, military service completed, four years experience in solo practice, desires relocation and association with individual or small group. Contact Box 747 in care of the Journal. p8

DOCTORS' OFFICE SPACE AVAILABLE in beautiful new Brentwood Medical Arts Building, 2018 North Sherman Avenue, Madison. Private doctors' parking, public parking (40 cars), acoustical ceiling, mahogany paneling, heat and air conditioning, large reception room, black top parking area, pharmacy in building. On bus line, convenient to schools and churches. Address replies to Box 715 in care of the Journal. tfn

FOR SALE: By widow of physician. Extensive, up-to-date medical library; 100 MA x-ray unit with fluoroscope; esophagoscope; spot film device; motor-driven Bucky table; also, Pelton sterilizer, proctoscope, floor model sphygmomanometer; sundry smaller items. Address replies to Box 746 in care of the Journal. m8–9

FOR SALE: 38-year-old successful clinic in west central Wisconsin, grossing $100,000 per year with more potential. Ideal arrangement for four physicians. Average 50 patients per day. 32-bed hospital operated in conjunction with clinic. Suitable brick building originally planned for clinic, with x-ray and ENT department. Situated in heart of Trempealeau county, prosperous rural area with great potential industrial development, covers area of 8,000 population, mostly Scandinavian, Polish and German, fine school, five churches, golf course, swimming pool, Scout organizations, good hunting, fishing. Sale made necessary because of two coronary attacks by owner, who prefers selling on a term basis. Contact Box 743 in care of the Journal. m8–9

FOR SALE: Office equipment, X-ray and lab. in well established 35-year general practice. Retiring because of age. Population 25,000. Excellent hospitals. Reasonable price for office equipment and X-ray takes practice. Wonderful opportunity for young man. Contact Box 737 in care of the Journal. m7–8

FOR SALE—Medcosonlator machine, a combination of ultra sound with the Medcolator which is a muscle stimulating device. 1956 model used very little. Contact C. W. Docter, M.D., 610 Sixth Street, Racine, Wis.

FOR SALE: Deceased physician's equipment—Fischer x-ray machine (looks like new), developing tank, casettes, sterilizer, microscope, centrifuge, examining table, some furniture, books, etc. Contact Box 739 in care of the Journal. 7–8

GENERAL PRACTITIONER AVAILABLE for locum tenens from Dec. 1, 1958, to Jan. 1, 1959, when I start orthopaedic residency. Have had some training in surgery and orthopaedics. Prefer Madison area or southern Wisconsin. Now stationed in Japan with Air Force. Have license to practice in Wisconsin. Address replies to Box 738 in care of the Journal. p7–8

MEDICAL AND SURGICAL GROUP would like to form association with young doctor interested in one, two, or three year appointment as assistant in surgery, and to assist in the handling of emergency and industrial cases. Contact Box 736, in care of the Journal. 7–9

PHYSICIAN'S OFFICE SPACE AVAILABLE: Desirable location on ground floor; 3 consultation rooms; share waiting room with dentist; situated on Capitol Drive, Milwaukee, Wisconsin. Contact Box 742 in care of the Journal. 8–9

RADIOLOGIST: For Capitol Hospital, Milwaukee, Wisconsin. Contact: Administrator, Capitol Hospital, 1971 West Capitol Drive, Hilltop 2–9100, Milwaukee 6, Wisconsin. 8tfn

WANTED: A young man, preferably out of his internship, to join two men in general practice. One man, age 50, member of the American Academy of General Practice doing general surgery. Another man, age 40, as a partner. Begin on salary basis; if satisfied, work toward partnership. Contact Box 744 in care of the Journal. m8–9

WANTED: General practitioner immediately to rent a general practice, fully equipped office with option to buy. Excellent opportunity for a secure, fast start. Call Fulton 6–4901, Juneau, Wis. m7–8

WANTED: Young physician to practice General Practice with a small group, consisting of a General Practitioner with an established practice of 30 years duration, plus a board certificate surgeon. Initial salary open. Desire is for early partnership. Contact Box 745 in care of the Journal. m8–9

WANTED: General practitioner in eastern Wisconsin city of 4,000, plus drawing population 5,000; 2 hospitals within 6 miles; industrial community; heavy rural population; office space available. Contact Box 740 in care of the Journal. p7–8

WANTED: General practitioner for group of three in small southern Wisconsin town. Clinic facilities available. Young man preferred. Contact Box 741 in care of the Journal. m8–9

WANTED GENERAL PRACTITIONER: General practitioner in Northwest Wisconsin desires association of a physician. Good hospital facilities. Address replies to Box 748 in care of the Journal. m8–9

WANTED GENERAL PRACTITIONER: Plum City, Wisconsin, Pierce county, population 400, would serve 6,000—looking for a general practitioner and surgeon who would be willing for an early opportunity, must be willing to do considerable obstetrics and surgery; one 32-bed hospital in town; office space and living quarters available. If interested contact Box 750 in care of the Journal. 8

FOR SALE: Standard 100 m.a. x-ray machine, fully equipped. Contact N. W. Erickson, M.D., FU 6–4901, Juneau, Wisconsin. m8–9

ORTHOPEDIST: Wisconsin graduate, now associated with Class A Medical School, is interested in locating in Wisconsin. Board Member. Association with group of other Board member desired. Write Box 749 in care of the Journal. 8–10*

WANTED: YOUNG GENERAL PRACTITIONER needed in Oconto Falls or Gillett, Wis. Cities of 2,100 and 1,500 population. The three doctors serving these communities and surrounding rural area of 12,000 population desire another physician in the area. Oconto Falls has community-owned, 37-bed hospital. Progressive cities with many shopping, entertainment, and social facilities. Opportunity to practice with congenial professional association. Address replies to J. R. Culver, M.D., or C. E. Siefert, M.D., Oconto Falls, Wis. m8tf

THE PRACTICE OF A. F. RHEINECK; Suite 310, 2218 North Third Street, Milwaukee, Wisconsin, is immediately available to a qualified practitioner; equipment may also be purchased. All interested parties contact Attorney William E. Glassner, Jr., 2218 North Third Street, Milwaukee, Wisconsin, FRanklin 4–0790. p8,tf

WANTED: Psychiatrists or young doctors interested in psychiatry to work at Mendota State Hospital. These positions are permanent and under Civil Service, salary depends upon previous experience and training. Housing available on grounds. Contact Dr. W. J. Urben, Superintendent, Madison 4, Wisconsin. 8–12

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THE WISCONSIN MEDICAL JOURNAL

Vol. 57 AUGUST 1958 Number 8

Arteriography*

By EUGENE E. SKROCH, M.D.

Madison

NO MORE accurate means of studying the pathologic anatomy of the major vessels is available than the radiographic visualization of their lumen by the injection of radiopaque solutions. The application of current surgical techniques in the treatment of many of the diseases of the arteries is dependent largely on such visualization. Aortography and peripheral arteriography succeed in visualizing most of the surgically important regions of these vessels. The larger vessels of the abdomen, including the celiac axis and its branches, the superior and inferior mesenteric arteries, and the renal arteries, can be visualized. The purpose of this paper is to discuss the techniques of aortography and peripheral arteriography which are adaptable to the ordinary equipment found in most general hospitals. There are many expensive refinements not usually available in a small general hospital; among these are 36-inch cassettes, cassette changers, mechanical equipment to empty syringes, etc.

INDICATIONS

Indications for arteriography are relatively limited and should be used in cases where it is suspected that surgical intervention may be indicated. The arteriogram will quite definitely determine the extent and location of disease and to a lesser extent the condition of the vessel involved. Indications for arteriography are:

(1) In certain cases of traumatic interruption of the arterial blood flow in a crushing type of injury, arteriography will help to differentiate spasm from actual anatomical occlusion. Arteriography again helps to localize the point of occlusion.

(2) An arteriogram will help to localize accurately the position of a peripheral arterial embolus and has been recommended by some for this purpose. When so used, one should be prepared to go ahead with surgery for embolectomy because the procedure may dislodge the embolus.

(3) By far the most common indication for peripheral arteriography is in degenerative arterial disease. The degenerative arterial diseases which are amenable to surgery and can be nicely visualized and localized include segmental arteriosclerosis in the distal aorta, aortic bifurcation, disease in the iliac or femoral arteries, or an aneurysm in one of these locations. Segmental disease is usually found in those cases where the chief symptom is intermittent claudication and where the ischemic changes and symptoms are minimal.[1] The arteries of the lower extremities may be visualized at either one of two levels. An aortogram shows not only the abdominal aorta but also its bifurcation and the iliac arteries. With the use of long casettes and good teamwork, aortography might be used in all cases. However, the greater simplicity and safety of femoral arteriography indicates its use in most instances. At times it may be difficult to decide whether to do aortography or femoral arteriography. In cases of absence of one or both femoral pulsations, aortography is indicated. When there are bilaterally equal and bounding femoral pulses, femoral arteriograms are the procedure of choice.

* Presented at meeting of the Wisconsin Surgical Society, Madison, September 20, 1957.

TECHNIQUES

Contrast Media: The first reasonably safe contrast medium to be used in arteriography was aqueous sodium iodide solution. It is still used by some today, but its use has been largely supplanted by the organic iodides which were developed primarily for use in intravenous urography. Of these the popular ones are iodopyracet (Diodrast), iodomethamate (Neo-Iopax), acetrizoate sodium (Urokon), and diatrizoate (Hypaque). Diodrast comes in 35 and 70 per cent concentrations; Neo-Iopax, 35 and 75 per cent; and Urokon and Hypaque, in 50 per cent solution.

I have been using the 50 per cent Hypaque solution which has given satisfactory contrast. The solution is not too viscid and reactions to the drug have been minimal. In spite of the high iodide content in all of these contrast media, iodine sensitivity reactions have been rarely reported. Prior to injection of the full volume of the solution for visualization, the patient is tested for sensitivity by injecting 1.0 cc. of the Hypaque intravenously. It is now generally agreed that conjunctival and intradermal tests are of very little value in determining sensitivity to these drugs.

Fig. 1—The value of the initial 5 cc. test dose is here demonstrated. It shows poor position of the film, intramural injection of dye and periaortic extravasation of dye.

Aortography: Translumbar aortography is usually done with the patient anesthetized. However, there are many individuals who do these with just a local anesthetic. The preoperative preparation is the usual preparation of a patient for a general anesthetic. Since the aortogram must be done with the patient in the prone position, it is important that an endotracheal tube be used for administering the anesthetic. The patient's back is cleansed with alcohol or some other antiseptic solution and draped with only four towels. A thin-walled, 16-gauge, 7-inch needle is then inserted into the abdominal aorta. This is accomplished by piercing the skin with the needle about 8 cm. lateral to the spinous process just below the twelfth rib. The needle is directed medially and slightly cephalad between the transverse processes until it touches a vertebra body. The needle is grazed off this vertebral body and about 2 cm. anterior to this point a slight bit of resistance and the pulsation of the aorta against the needle is encountered. The needle is then inserted about 1 cm. farther and a hollow sensation is felt. The stylet is removed from the needle and if aortic puncture has been accomplished, the blood wells up about 1 cm. with each heart beat. Plastic tubing, with a saline-filled 30 cc. syringe attached, is connected to the needle and the needle is kept open by slowly injecting the saline. By occasionally releasing the pressure on the plunger of the syringe, one can tell if the needle is still within the lumen of the aorta by seeing the blood pulsate back into the tubing and syringe. When the x-ray technician is all set to take the x-ray, the saline-filled syringe is replaced by one containing 8 cc. of 50 per cent Hypaque (8 cc. is used because the tubing and needle hold about 3 cc. leaving 5 cc. for the injection). The dye is then injected as rapidly as possible; and, as the last 1 or 2 cc. are being injected, the operator gives a predetermined signal for the x-ray exposure to be made. A saline-filled syringe is again attached to the tubing to keep the tubing and needle from becoming occluded by clotting blood while the x-ray film is being developed. This preliminary procedure serves the purpose of checking for proper position of the needle, to make certain that there is no extravasation of dye, and to make sure that the needle is not within a renal artery nor directly opposite the celiac axis or superior mesenteric artery (fig. 1).

If the needle is not properly placed, it can be removed and replaced in a more desirable and safe location and this preliminary check repeated. This initial procedure also checks the position of the film, and the adequacy of exposure. Occasionally in high, complete obstructions this 5 cc. dosage is adequate for the visualization desired and no further injection of dye need be done and probably had better not be done to avoid possible spinal cord injuries.

If the position of the needle and the film are satisfactory and the exposure right, 30 cc. of 50 per cent Hypaque is now injected as rapidly as possible and as the last 2.0 cc. are being injected the film is exposed. One hopes that everything will turn out satisfactorily because it is not safe to repeat the injection of this amount of dye into the aorta at the same sitting.

The amount of x-ray exposure used is roughly that required to get a good lumbosacral spine film. A 14 x 17 film will show quite adequately the abdominal aorta, the bifurcation, and the common and external iliac arteries (fig. 2).

Fig. 2—A translumbar aortogram visualizing the abdominal aorta aortic bifurcation, common iliac arteries, external and internal iliac arteries, the common femoral artery and the proximal portion of the superficial femoral artery. An arteriosclerotic occlusion of the right common iliac artery is shown.

Fig. 3—A femoral arteriogram done by the percutaneous route using simply a syringe and needle. A segmental occlusion of the superficial femoral artery is nicely demonstrated.

Femoral Arteriograms: When there is a fairly satisfactory femoral pulse, most femoral arteriograms can be done by the percutaneous method. When doing only an occasional arteriogram, a satisfactory film is obtained by simply using a 20 cc. syringe with an 18-gauge needle attached and injecting the dye directly into the artery (fig. 3). The film can be exposed just as the last 3 or 4 cc. of dye are injected. This gives good visualization from the groin to the popliteal space, but gives no information about the lower leg. Another unsatisfactory feature of this technique is the marked exposure of the operator's hands to roentgen rays; therefore, if doing more than an occasional arteriogram, it is best to use plastic tubing with adaptors to keep the hands away. In doing this, I usually insert the 18-gauge needle attached to a 5 cc. syringe after preliminary infiltration with a local anesthetic. The skin is cleansed with 70 per cent alcohol and no drapes are used. The needle is inserted into the artery by palpating the artery with the fingers of the left hand and with the other hand directing the needle toward the artery and somewhat cephalad. There is no question about

when the artery is entered; there is a very definite pulsation of bright red blood into the syringe. If it is necessary to aspirate to get blood, it usually means that the needle is in the femoral vein. The plastic tubing connected to the 20 cc. syringe containing 50 per cent Hypaque solution is then attached to the needle. The dye is injected as rapidly as possible and as the last 1 or 2 cc. are injected, the x-ray picture is taken. In the past we have overlapped two cassettes so that the entire leg could be x-rayed at one time. One-half of the cassette was covered with lead shielding, and immediately after the first exposure the leg was moved to the other half of the cassette. Then the lead shielding was moved to cover the previously exposed portion of the x-ray film and another picture taken. With the aid of three technicians working as rapidly as possible, we got the second shot in about 15 seconds which usually proved to be a little late and the exposure of the lower leg was unsatisfactory. We have since constructed a very simple and cheap apparatus to overcome this problem of changing the film. An x-ray tunnel, the length of two 14 x 17 films and one and one-half times the width of one film, was constructed of plywood. The surface is divided into thirds and the two lateral thirds are covered with a lead shield. A special cassette is made of a dark oil cloth folded in half, sewed down the sides and through the middle. A zipper is sewed into each end forming two compartments, each large enough for a 14 x 17 inch x-ray film. All that separates the two films is the width of a sewing machine seam or about 2 mm. This cassette is inserted into the above described tunnel, one-half of the film is exposed first, and the cassette can be shoved in and the second one-half exposed in about seven seconds (fig. 4).

Fig. 4—An arteriogram of the entire leg according to technique described in the text. The value of serial films is here demonstrated; the second exposure is approximately 10 seconds after the first.

COMPLICATIONS OF LUMBAR AORTOGRAPHY AND FEMORAL ARTERIOGRAPHY

There is an excellent review of the complications of translumbar aortography in the May, 1956, issue of the *American Journal of Roentgenology* by McAfee and Willson.[2] I will not go into a detailed discussion of these complications but shall only list them. Fortunately, I have not had personal experience with any of these complications. The most important and most frequent complications are renal damage from reaction to the contrast media, bleeding from the puncture site, and intestinal damage from direct injection into the superior mesenteric artery. Systemic reaction to the contrast medium was important when sodium iodide was used, but now this is of minor importance with the use of organic iodides. Other complications include perforation of a viscus, injection of other branches of the aorta, air embolism, periphpheral vasospasm, cerebral complications,

spinal cord paralysis, pneumothorax, and chylothorax. Fortunately most of these complications are not serious and fatalities are rare. There are series of up to 3,500 cases reported without a fatality. Illustrated in figure 1 is a case of an intramural injection plus some extravasation of the test dose without ill effects.

Complications of femoral arteriography reported are thrombosis, embolization due to dislodgement of an atheromatous plaque, vasospasm, hematoma formation, and femoral neuritis due to extravasation of dye.[3] I have inadvertently injected 20 cc. of 50 per cent Hypaque into the tissues of the groin without ill effect other than severe pain at the site of injection for about 15 minutes.

In conclusion, then, aortography and arteriography are important and helpful diagnostic aids which are within reach of the average general hospital with an x-ray department. No expensive or special equipment is required. If a few simple precautions are observed, no serious complications should occur.

TABLE I—*Femoral Arteriogram Tray*

(For Both Legs)

2—20 cc. syringes
2—5 cc. syringes
3—2½-inch, 18-gauge needles
2—1½-inch, 23-gauge needles
40 cc.—50 per cent Hypaque
10 cc.—1 per cent Procaine
1—18-inch plastic tubing with Luer-lok connectors

TABLE II—*Tray For Aortography*

2—7-inch, 16-gauge needles with stylet
2—Curved hemostats
4—Towels
2 pair—Rubber gloves
30 cc.—50 per cent Hypaque
1—500 cc. stainless steel basin
1—50 cc. stainless steel container
1—18-inch plastic tubing with Luer-lok connectors
3—30 cc. Luer-lok syringes
1—10 cc. Luer-lok syringe
250 cc. Normal saline

SUMMARY

(1) Techniques of aortography and peripheral arteriography are discussed.

(2) A simple device for full leg arteriograms is described.

(3) The hazards of arteriography are listed.

(4) The indications for this important diagnostic aid are listed.

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Comments on Treatment

Editors—F. E. SHIDEMAN, M. D., University of Wisconsin, Madison
HARRY BECKMAN, M. D., Marquette University, Milwaukee

The Therapeutic Diagnostic Test in Anemia

The ultimate proof of deficiency anemia requires that there be demonstrated (1) a subnormal tissue or serum concentration of the nutrient, and (2) a reticulocyte and hemoglobin rise at appropriate intervals following the institution of specific therapy. The classical examples of nutritional deficiency causing anemia are iron deficiency and vitamin B_{12} deficiency. Folic acid deficiency is a distinctly less common cause of anemia in the Temperate Zone.

The measurement of serum iron is useful in screening for iron deficiency. Probably more informative is the microscopic examination of aspirated bone marrow particles for iron. These iron-containing granules are visible as golden yellow droplets or granules in the unstained marrow particles. They may further be identified by special staining for iron, as is done in any pathology laboratory. In iron deficiency, there will be little or no recognizable iron-containing material in the marrow aspirate. Before one can evaluate such a preparation, one must have studied a few smears of marrow with normal iron content. The classical clues to iron deficiency are those of hypochromia and microcytosis in the peripheral blood. Thalassemia minor is a hematologic condition in which there is hypochromia and microcytosis, but serum and tissue iron stores will be normal, and iron therapy is not of help.

The second criterion mentioned above for the establishment of deficiency anemia is the rise in reticulocytes and hemoglobin at appropriate time intervals after the institution of specific therapy. A common error is to give more than one therapy at one time. It is crucial that only iron be given if one is to attribute the response to iron. If a multihematinic is given to a patient with anemia, one does not know which of the several agents caused the hematologic response. This is especially pertinent in pernicious anemia (vitamin B_{12} deficiency) because this diagnosis carries with it the *need for a lifetime* of injections of vitamin B_{12} at monthly intervals.

The reticulocytes must be counted at least once before therapy is started; because if one enumerates these cells on the sixth, seventh, and eighth days after therapy and finds them distinctly above normal, one must know that the level was normal or low before starting treatment. It would be unfortunate to conclude that a patient has pernicious anemia because the reticulocyte count was 12 per cent on the seventh day after injecting B_{12}, when in reality the patient had hemolytic anemia and the reticulocyte count had been around 10 to 15 per cent for months.

The therapeutic diagnostic test is of real help in establishing the diagnosis of iron deficiency or vitamin B_{12} deficiency anemia, but in order to interpret such a test only one therapy may be given at a time. The multihematinic tablet has no place in the treatment of anemia—ROBERT F. SCHILLING, M. D.

RELEASE FILM ON REHABILITATION OF CRIPPLED CHILDREN AND ADULTS

A dramatic new documentary film portraying the heart-warming stories of the rehabilitation of five crippled children and adults was released July 10 by the National Society for Crippled Children and Adults.

Dean W. Roberts, M. D., executive director of the National Society announced that the new film, titled "Reach for Tomorrow," presents a graphic report typical of the thousands of Americans who are being helped to health and usefulness by Easter Seal services through 1,700 Easter Seal Societies across the nation.

Prints of the film are available for purchase at $100.00 and, on a rental basis, to professional groups for $3.50. Purchase and bookings of "Reach for Tomorrow" on loan can be obtained by contacting Miss Catharine Bauer, director of information, the National Society for Crippled Children and Adults, 11 South LaSalle Street, Chicago 3, Illinois.

Diffuse Polyposis of the Colon*

Discussion and Case Presentation

By DAVID V. ELCONIN, M. D., F. A. C. S., and ARNOLD N. ELCONIN, M. D.

Milwaukee

POLYPS of the colon and rectum can be classified into five types: (1) polypoid adenoma, (2) villous tumor, (3) familial polyposis, (4) congenital polyposis of the entire intestinal tract (Peutz–Jeghers syndrome), and (5) pseudopolyposis. This paper is concerned with familial polyposis of the colon, also known by the following synonyms: hereditary multiple polyposis, diffuse polyposis, polypoid adenomatosis, and multiple adenomatoses.

This lesion was first reported by Menzel in 1721 and was accurately described by Virchow in 1863 in a 15-year-old boy. Cripps,[1] in 1882, first recognized the familial nature of the condition, describing cases in a brother and sister.

The condition involves the appearance in childhood of innumerable small adenomatous polyps in the colon and rectum. The large intestine may be the seat of numerous isolated or clustered adenomas with intervening normal mucosa; or the colon may be studded with adenomatous polyps of varying size, shape, and degree of development with no or very little intervening normal mucosa. The polyps may vary in size from those barely visible to the naked eye to those several centimeters in diameter, either sessile or pedunculated. Rarely is the appendix or entire gastrointestinal tract involved. One case was reported in which the entire rectum was free of polyps. Cases with less than a dozen polyps usually do not represent the true condition; and, in most instances, the differentiation is easy because in familial polyposis the polyps are usually literally innumerable.

Other defects have been reported in association with familial polyposis. Weiner and Cooper,[2] in 1955, discussed the occurrence of osteomatosis (a hereditary disease of membranous bone formation) and soft tissue tumors in association with multiple polyposis of the colon in four brothers. Fibrous tissue tumors may develop in incisions in these individuals. Multiple cartilaginous exostosis in association with multiple polyposis of the colon was reported by Zanca[3] in 1956. Oldfield,[4] in 1954, reported the association of familial polyposis of the large intestine with multiple sebaceous cysts in three cases. Sporadic cases of the rare familial disease in which adenomata of the small bowel, and possibly the colon, are associated with congenital pigmentation (melanin) of the oral mucous membrane, lips, and fingers have been reported. This is probably a separate disease entity and is mentioned above as the Puetz–Jeghers syndrome.

EQUAL FREQUENCY IN BOTH SEXES

Familial polyposis of the colon occurs with equal frequency between the sexes. Dukes[5] of London, England, in 1952, reported a study of 41 families with polyposis which included 753 people. Of this group 77 males and 79 females (156 people) have so far shown evidence of polyposis. Mayo *et al.*,[6] in 1951, in a review of 95 cases seen between 1932 and 1947, reported that 77 per cent of the cases were diagnosed between the ages of 20 and 40 years. The youngest patient reported with this disease was an infant 4 months old (LeFevre and Jacques,[7] 1951). The polyps were of such large size as to force the belief that they must have been present prior to the birth of this child.

Dukes and Lockhart–Mummery's[8] statistical analysis of 33 families revealed that in 22 families more than one member was affected. In 11 families only one member was affected. In the 22 families in which more than one member was affected, Dukes proves statistically that in them polyposis is a hereditary disease; that either males or females can transmit the disease; that in most polyposis families only half the children are likely to inherit the abnormality with the remainder being normal; that as a rule only those who have inherited polyposis can transmit it

* Presented at meeting of the Wisconsin Surgical Society, Madison, September 20, 1957.

to the next generation; and, that in families in which polyposis develops early in life cancer frequently occurs within 10 to 15 years, whereas in families in which polyposis occurs later the precancerous incubation period is longer so that the patients may die of natural causes before intestinal cancer has had time to develop. In human disease caused by dominant genes, a marriage between a heterozygote (affected) and a homozygote (unaffected) results in approximately half the children being affected. This finding is observed in most families afflicted with polyposis. If two heterozygotes (or two affected individuals) were by chance to mate, theoretically three-fourths of the offspring would be affected. The question as to whether solitary cases of multiple polyposis are a different disease entity than obviously familial cases requires further investigation. However the comparison so far made between solitary and obviously familial cases of polyposis has not revealed any difference in the size, number, or distribution of the tumors, nor any difference in the age of onset, symptoms, or course of the disease. A further period of observation may show that some of these solitary cases are the first manifestation of a gene mutation; and, although these patients have not inherited polyposis, they may transmit it to their offspring. Patients with this disease should best be advised not to have children.

MALIGNANCY A STRONG POSSIBILITY

Patients with familial polyposis have a strong tendency to develop malignancy. In Dukes series, 55 males and 59 females, a total of 114 out of 156 people (or 73 per cent), have already developed carcinoma of the colon and rectum. Brasher[9] (1954) studied two families with familial polyposis of the colon. In the first family there were five generations including 84 individuals. Two had polyposis, eight had carcinoma of the large bowel, three had proven polyposis and carcinoma of the large bowel. Thus, 13 out of 84 were affected (15 per cent). Of these 15 per cent affected, 11 out of 15, or 73 per cent, had carcinoma of the colon or rectum. In the second family studied by Brasher there were 103 people including eight with polyposis, three with carcinoma of the large bowel, and five with polyposis plus carcinoma of the large bowel, a total of 16, or 16 per cent, affected. Of those affected 8 out of 16, or 50 per cent, developed carcinoma. Durham[10] (1954) reported a family of three generations in which 18 of 29 members had polyposis or carcinoma of the colon, and 9 of those affected (50 per cent) had carcinoma. It is possible that the chances of any single polyp becoming carcinomatous in a case of familial polyposis may be no greater than in cases of occasional polyps. The inevitability of development of carcinoma may depend on the huge number of polyps, so that the combination of the many little chances adds up to certainty. According to Dukes[11] (1952) the expectation of life of a patient with familial polyposis of the colon is 41.6 years.

The diagnosis of diffuse polyposis of the colon is usually not difficult if the condition is kept in mind in any patient with persistent diarrhea and rectal bleeding. The patients are usually between 20 and 40 years of age, and approximately 50 per cent of the patients will have a positive family history. Physical examination, aside from evidence of anemia, is usually negative except in those cases in which carcinoma of the rectum has occurred. The polyps can be palpated in the rectum in some cases. Sigmoidoscopic examination and barium enema x-ray studies will invariably render a positive diagnosis. In the Mayo series (1951) blood in the stools or diarrhea or both were present in 95 per cent of 95 cases reported. Physical examination was negative except for the rectum in all cases except those in which carcinoma had supervened. Sigmoidoscopic examination was positive in 100 per cent and roentgen studies were positive in 100 per cent of those cases studied by these methods.

TREATMENT

The treatment of familial polyposis of the colon and rectum should be radical, according to all authorities. The choice of therapy lies between: (1) disposal of the polyps of the terminal colon and an anastomosis of the terminal ileum to the technically lowest possible level of the terminal colon, followed by subtotal colectomy and periodic observation of the preserved rectum, or (2) total colectomy, with an abdominal or anal ileostomy. The first method is favored by many surgeons when feasible. Anschuetz[12] lists four criteria that must be fulfilled for the institution of this conservative procedure: (1) absence of carcinoma of the rectum, (2) remaining rectum and anastomosis must be

within reach of the sigmoidoscope, (3) remaining rectum and anastomosis must be free from adenomas, and (4) after the operation the follow-up endoscopies plus appropriate destruction of new or recurrent polyps are to be performed every three months for the remainder of the patient's life. The disposition of the polyps in the terminal bowel is usually effected by means of surgical diathermy through the endoscope. At the Mayo clinic the abdominal operation is carried out first in order to save time consumed by the coagulation and three additional months needed for subsidence of the inflammatory reaction incident to the coagulation. The Mayo clinic surgeons prefer the end-to-end anastomosis over the side-to-side or side-to-end. Lockhart–Mummery, *et al.*[13] (1956) cited three reasons for their leaving the rectal stump under close proctoscopic supervision in selected cases: (1) the risk of carcinoma arising under adequate supervision is small in their hands (1 case in 27 or 4 per cent), (2) the dislike of the patient for permanent ileostomy, and (3) the special complications of ileostomy apart from its social disadvantages.

This conservative method has opponents as well as adherents. Ravitch[14] (1948) termed it a "dangerous half measure." Other authors[15,16] prefer total colectomy in one or more stages, primarily as a prophylaxis against the frequent development of rapidly growing and lethal cancers in the retained segment of rectum or rectosigmoid. They also point out that persistent ill health and anemia may result from slight constant blood loss from polypi in even a short segment of colon. Total colectomy with anal ileostomy is advocated by Best[17] (1948), Ravitch[18] (1948), and Devine and Webb[19] (1951). In this operation the mucosa with the adenomas is resected, but the rectal wall with its parasympathetic innervation is attached to the ileum. Thus, not only the rectal sphincter muscles but at least 6 to 8 cm. of the rectal stump are preserved with the undamaged parasympathetic nerve supply, which is so necessary for the maintenance of continence. After a lapse of time, the ileum may take over the function of a reservoir. However, this procedure is more difficult for the average surgeon to perform than abdominal ileostomy, which is usually the procedure of choice. The preferred age for elective operation in familial polyposis, according to Lockhart–Mummery *et al.*, [13] is in the late teens or as soon thereafter as the condition is diagnosed. This is based on the occurrence of carcinoma in two of their patients with familial polyposis at the age of 20 and the report of cases in the literature at an even younger age than this. Cancer usually develops within 10 to 15 years after the first onset of symptoms.

CASE PRESENTATION

This is the case of a 29-year-old woman with diffuse polyposis of the colon and rectum with frank carcinoma, probably developing from polyps in two places about 15 cm. from the anal margin. She was treated by a one-stage combined total colectomy and abdominal perineal resection of the rectum and abdominal ileostomy. Survival has now been one year with no sign of recurrence of the malignancy to date.

The patient, a 29-year-old housewife, was admitted to Mount Sinai Hospital of Milwaukee on September 13, 1956. Her history dated back eight years prior to admission when, during the fourth month of her first pregnancy, she developed bloody diarrhea. The stools were liquid and bright and dark red and consisted of 4 to 11 bowel movements daily. She was hospitalized that time at another hospital and was told that she had bleeding hemorrhoids. She was treated symptomatically and the bleeding stopped. However, after dismissal from the hospital, the bleeding continued intermittently. In 1951, she had a severe hemorrhage accompanied by a fainting spell and was hospitalized at another hospital and a hemorrhoidectomy was done. Upon dismissal from the hospital the bleeding recurred and she was x-rayed in a doctor's office. She was told that she had ulcerative colitis. Since that time, she was hospitalized approximately 15 times for the treatment of this condition with improvement and eventual remission each time. In 1953, she had a spontaneous abortion and noted abdominal cramps for several years thereafter. She was told that she had infected ovaries and was treated with diathermy. In late July, 1956, she had chills, malaise, continuous bloody diarrhea, vomiting, abdominal pain, fever which rose to 103 F., and a 21-pound weight loss over a two-week period.

She was then referred to a proctologist who did a barium enema and proctoscopic examination and biopsy revealing diffuse

polyposis of the colon and rectum with malignant change. The past history revealed that the patient was a gravida three, para two. An appendectomy was performed 12 years ago. A tumor in her appendectomy scar had been removed two years previously. Sebaceous cysts were removed from over her right eye 20 years ago, from over the calf of the left leg and neck seven years previously. Family history revealed that her father, father's mother, and father's three sisters all have multiple sebaceous cysts but no evidence of polyposis. Her maternal grandmother died of carcinoma of the bowel at age 62. Her maternal great grandmother died of carcinoma of the stomach. Her father, age 54, is living and well. Her mother, age 48, is living and well. One sister, age 28, and her three children are all living and well with no sign of polyposis. Two brothers, ages 21 and 26, and their children are living and well with no sign of polyposis. The patient's daughters, ages 7 and 9, are healthy.

Physical examination revealed a thin, chronically ill woman in no acute distress. The pulse was 120, blood pressure 105/60, respirations 16, temperature 98.6 F. The following were the positive findings: There were firm, freely movable, nontender superficial masses over the scalp, right fourth finger, and medial and lateral aspects of the right tibial region. Examination of the abdomen revealed a well-healed appendectomy scar and a soft, distended, but slightly tender abdomen throughout. Digital examination of the rectum revealed multiple polyps and a hard mass anterior to the cervix with crater formation typical of carcinoma. Sigmoidoscopic examination revealed multiple polyps over the entire rectum. At the 12 cm. level was a bleeding tumor which was biopsied and eventually showed adenocarcinoma. Laboratory studies on admission showed hemoglobin 13.6 gm., hematocrit 50/50, leukocyte count 11,100 cells/cu.mm.; the differential count revealed nonsegmented polymorphs 12 per cent, segmented polymorphs 50 per cent, lymphocytes 32 per cent, eosinophils 3 per cent, monocytes 3 per cent. The urine specific gravity was 1.005, Ph. acid, albumin tested negative, sugar tested negative, microscopic examination of the sediment revealed 8 to 10 leukocytes, occasional erythrocytes, and a few epithelial cells. Chest x-ray was negative. Upper gastrointestinal and small bowel series x-rays were negative. Colon x-rays revealed diffuse polyposis of the rectum, sigmoid, and descending and transverse colon. Filling defects in the cecum could not be interpreted definitely as polyps.

The bowel was prepared with oxytetracycline and neomycin for three days and on September 24, 1956, the patient was taken to surgery. The plan preoperatively was to resect the lower bowel containing the carcinoma first. If the patient's condition did not permit, a colostomy would be done and a second-stage colectomy and ileostomy would be done at another time.

A long left rectus muscle splitting incision was made. On exploring the abdomen, the entire large bowel, sigmoid, and rectum were found to be full of polyps. Low in the rectum, about 15 cm. from the anal margin, the carcinoma could be seen and palpated. There were no gross metastases, but the serosal surface of the bowel containing the carcinoma was contracted and indurated. There were no obvious nodes containing carcinoma. The sigmoid and rectum were mobilized, exposing the course of the left ureter. The rectum was freed laterally, anteriorly and posteriorly down to the tip of the coccyx. The inferior mesenteric artery was ligated. The entire colon was mobilized and freed from the mesocolon and greater omentum. The upper part of the rectum was ligated and severed.

The patient's condition was reported by the anesthesiologist as excellent and so it was decided to attempt the entire procedure in one stage. The entire colon was then removed after first exposing and identifying the right ureter and duodenum. A new peritoneal floor was made by suturing the lateral leaves of peritoneum using the uterus to form a portion of the peritoneal floor. A stab wound was made in the right rectus muscle and the terminal ileum was brought out through this stab wound as a permanent ileostomy. The peritoneal edge of the mesentery to the terminal ileum was sutured to the right anterior peritoneum. The abdomen was then closed and the patient was placed in the lithotomy position and the rectum was removed perineally.

The specimen consisted of two parts: the entire colon, and a portion of the rectum 7 to 10 cm. in length. The large segment of colon removed was somewhat distended especially in the ascending and transverse portions. The serosal surfaces were smooth except for an

Fig. 1—This represents the entire specimen. Note the progression in size of the polyps from very tiny, sessile polyps in the cecum to large, often pedunculated polyps more distally. The two frank carcinomas in the rectum are outlined by arrows.

Fig. 2—This is an enlargement of the carcinomas in the rectum. Note the two large pedunculated polyps between the two carcinomas.

area about 6 cm. from the distal amputated end where there was a zone of induration and contraction about 5 to 7 cm. in diameter. There were very few lymph nodes and those present failed to reveal any evidence of tumor grossly or microscopically. Upon opening the specimen it was clear that this was a case of diffuse polyposis of rather extreme degree. In the proximal 20 to 30 cm. the polyps were extremely small nonpedunculated and hardly discernible. The remainder of the specimen, the total length of which was 120 cm., was involved by polyps ranging from very tiny ones to some as large as 5 cm. Some of these polyps were closely flushed with the mucosal margin; others were lying at the end of a long slender mucosal pedicle, sometimes as much as 7 to 10 cm. in length. The ends of these polyps ranged from about ½ to 3 cm. in diameter.

Two different tumors were present, however, at the distal end. One of these was an extensively ulcerated, typical crater-penetrating adenocarcinoma and this was about 8 cm. from the amputated end. It embraced the entire circumference of the specimen and had a longitudinal axis of about 5 cm. Distal to this by just a couple of centimeters was a flat, mutipolypoid, firmly fixed tumor 4 cm. in diameter which resembled the other polyps except that it was broadly based and could not be separated from the underlying mucosa. This was also malignant. Further inspection of many of the polyps disclosed changes consisting of excessively papillary transformation of the mucosa, which at least must be considered as noninvasive carcinoma. The second specimen consisting of the anus and rectum measured 7 to 10 cm. in length. The mucosa was studded with small polyps.

Postoperatively the patient had a stormy course necessitating operative intervention for intestinal obstruction on the twenty-eighth postoperative day and a revision of the ileostomy 46 days after the first operation. Nevertheless, the patient was dismissed from the hospital 57 days after the first operation with a good functioning ileostomy. Since that time she has gained 20 pounds and is asymptomatic. At this time, one year from

the time of surgery, there is no evidence of recurrence of the malignancy.

SUMMARY AND CONCLUSIONS

Diffuse polyposis of the colon is a specific disease entity in which innumerable small adenomatous polyps are found in the colon and rectum. It is an hereditary disease caused by a dominant gene, although solitary cases occur. It occurs with equal frequency between the sexes; and, although it is found in young children, it is usually discovered in the second and third decades. Patients with diffuse polyposis have a strong tendency to develop malignancy and therefore should be treated early and radically. The choice of treatment lies between: (1) subtotal colectomy and ileocolostomy with fulguration of the polyps in the terminal large bowel and frequent future endoscopic examinations for the lifetime of the patient, or (2) total colectomy and abdominal or anal ileostomy.

A case report of diffuse polyposis of the colon with carcinomatous change is presented. The patient was treated by a successful one-stage combined total colectomy, abdominal perineal resection of the rectum, and abdominal ileostomy. This report is presented as a case of familial polyposis of the colon and rectum because of the extreme multiplicity of the polyps and the patient's youth (21 at age of onset of symptoms). The fact that no other member of the family is similarly affected does not detract from the diagnosis. It is inconceivable that so many thousands of polyps could develop in so young a woman on any other basis.

The presence of multiple sebaceous cysts occurring in the patient and her paternal family is an interesting sidelight; and its exact relationship to the polyposis is unknown at this time, although other authors have reported similar findings.

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INTERNATIONAL COLLEGE OF SURGEONS TO OBSERVE SECOND ANNIVERSARY OF FOUNDING OF CONTINENTAL FEDERATIONS OF SURGEONS

The second anniversary of the formation of World Federations of Surgeons on a continental basis within the structure of the International College of Surgeons will be observed in Chicago, Friday, September 19, 1958. Further information may be had by writing to International College of Surgeons, 1516 Lake Shore Drive, Chicago 10, Ill.

Cholecystitis with Cholelithiasis in Childhood*

Report of a Case in a Five-Year-Old Boy

By GEORGE P. SCHWEI, M. D., F. A. C. S.

Menasha

AGE AND SEX INCIDENCE

ACUTE and chronic cholecystitis, with or without stones, generally considered an uncommon disease of childhood, actually is not rare. Potter,[1] in 1928, reviewed 226 reported cases of primary gallbladder disease in children ranging in age from birth to 15 years. In 1938[2] he reported an additional 206 cases. Ulin *et al.*[3] in 1952, reviewed all cases including Potter's. He found 475 cases from 1762 through 1948 and added 30 cases reported since 1948. Congenital biliary tract defects, congenital hemolytic icterus, and sickle cell anemia were excluded.

Potter, in 1928, stated that of 25,000 cases of gallbladder disease, the average age at the time of surgery was 36 for females and 39 for males. In 1950 Arnold Jackson and I[4] reviewed the age and the sex incidence of 1,100 operative cases at the Jackson Clinic and found that 875, or 75 per cent, were females with an average age of 51 years; and 275, or 25 per cent, were males with an average age of 59. In the 10-to-20-year group the incidence was less than 1 per cent (7 females). The 20-to-30-year group had few males, but included 10 per cent of the females.

FAMILIAL INCIDENCE

Little has appeared in the literature concerning the familial incidence of cholecystitis and cholelithiasis. Dixon and Owen,[5] however, in 1952 emphasized the familial incidence in their report of three separate families and concluded there was a definite indication that hereditary factors predispose to the development of gallstones. In one family of eleven siblings, seven females had proved cholelithiasis. Three male members and one female were apparently free of the disease. The second family of fourteen siblings had six females with cholelithiasis and three others with gallbladder symptoms. The third family had three sisters, a mother, and maternal uncle and aunt—all with gallstones. The case to be presented later had a most unusual familial incidence.

COMPARISON OF CHILDHOOD WITH ADULT CHOLECYSTIC DISEASE

There are several distinguishing features to be considered in comparing the childhood disease with that of the adult. Obviously the "F" mnemonic—fair, fat, flabby, fertile, flatulent, female of 40—will not enter our discussion.

Etiology: Infection plays a more important role in the childhood disease. Acute systemic diseases such as hemolytic Streptococcus septicemia with acute glomerulonephritis and scarlet fever have caused secondary acute cholecystitis. Typhoid fever previously was a known etiologic factor, but the incidence in the United States is now practically nil. In the child, cholelithiasis may be caused by the increased excretion of bile pigments in hemolytic anemia. Gross[6] believes this association is so frequent that cholelithiasis in childhood should always arouse suspicion of a blood disorder. Of six children (ages 3 to 14) he operated upon, three had hemolytic anemia.

Sex: In children with cholecystic disease the ratio of males to females is 3:2; while in adults, females outnumber males 4:1.

Symptoms: Abdominal pain is usually not localized in the child; umbilical pain may predominate. The pain is not referred to the shoulder or back as is often true in the adult.

Nausea and Vomiting: The incidence of nausea and vomiting in cholecystitis is the same in children as in adults. The typical dyspepsia—food idiosyncrasy, fullness, and belching—common in the adult, is not usually found in the child.

* Presented at meeting of the Wisconsin Surgical Society, Madison, September 20, 1957.

Comparison of Childhood and Adult Cholecystic Disease

	Childhood	Adult
ETIOLOGY	Infection—acute systemic disease Hemolytic Streptococcus Septicemia with acute glomerulonephritis. Scarlet Fever. Typhoid. Cholelithiasis—due to hemolytic anemia.	Acute systemic infection rare. Cholelithiasis due to faulty cholesterol—fatty acid metabolism
SEX	Male 3:2	Female 4:1
SYMPTOMS Pain	Abdominal pain, not localized. Umbilical pain may predominate. No radiation of pain to back or shoulder.	Right upper quadrant pain. Radiates to back or shoulder.
Nausea Vomiting	Nausea and vomiting present.	Same.
Dyspepsia	Food—fat intolerance—belching not common.	Food dyscrasia—belching common.
Jaundice	Present or past—26-45% Common duct stones—6% Jaundice cases—95% No common duct stone Low incidence of common duct stone, high frequency jaundice.	8-10% Common duct stones—17% Jaundice cases—53% No common duct stone Higher incidence of common duct stone with lower incidence of jaundice.
Gallstones	60% are pigmented	80%—cholesterol—calcium
DURATION	Short—days, weeks, months	Months, years, chronicity with recurrences and exacerbations.
PATHOLOGY	Microscopic evidence of acute inflammation with polymorphonuclear and bacterial infiltration. Primary malignancy non-existent.	Chronic reaction with edema necrosis—lymphocytic infiltration fibrosis. Primary malignancy—1 to 3%.
SURGERY	Results: cholecystectomy—excellent. Cholecystostomy and removal of stones O.K. in congenital hemolytic anemia. If anemia has or will be corrected, exploration of common duct not as urgent.	Same. Cholecystostomy usually not done. Exploration of common duct mandatory with past or present jaundice.

Jaundice: The incidence of jaundice in cholecystic disease is greater in children than in adults. As noted in the comparison table, there is a much lower incidence of common duct stones, with a higher frequency of jaundice in children.

Duration of Disease: The shorter duration, weeks or months, is typical of childhood gallbladder disease while chronicity, with recurrences and exacerbations often over a period of many months or years, is characteristic of the adult form.

Pathology: Microscopic examination of the gallbladder in childhood cholecystitis reveals evidence of acute inflammation with polymorphonuclear and bacteria infiltration in the wall. The adult gallbladder exhibits a chronic inflammatory reaction with edema necrosis and lymphocytic and neurolytic infiltration. The incidence of primary gallbladder malignancy in the adult is said to be 1 to 3 per cent; in the child, it is practically nonexistent.

Surgery: Results are uniformly excellent in both child and adult cholecystectomies. Occasionally cholecystostomy and removal of the calculi, especially if the child has congenital hemolytic anemia which has or will be corrected, will suffice. The need for exploration of the common duct, though not as urgent in a child, is mandatory with a past or present history of jaundice in an adult.

CASE PRESENTATION

The patient, a five-year-old male, was born August 30, 1951. When he was a year old, he was admitted to the hospital because of nausea, vomiting, and watery stools. A diagnosis of acute gastroenteritis was made, appropriate treatment given, and the patient was discharged well, four days after admission. His next hospital admission was at the age of four (January 1956). He had generalized abdominal pain, fever, nausea, and vomiting for three days. His skin and sclera had a slight icteric tinge, the urine contained a trace of bile, and the stools were acholic. The boy remained in the hospital for seven days and was discharged with a diagnosis of viral hepatitis.

His present hospital admission was on September 24, 1956. One week prior, the family physician observed the patient in his home for what he thought was an atypical appendicitis. Three days later, the mother observed an icteric tinge of the sclera, dark urine, and somewhat lighter stools. The vague

abdominal distress continued and the patient was admitted to the hospital. Physical examination revealed a well-developed, well-nourished white child, age 5, who did not appear acutely ill. The temperature, pulse, and respirations were normal. The entire physical examination was essentially negative except for tenderness on palpating the right upper quadrant. The liver and spleen were not palpable.

Family History: The father, age 35, had jaundice when he was 13; a cholecystostomy was done, and over 100 small faceted stones were removed. His only sister required a cholecystectomy at 23 years of age. Their mother the boy's paternal grandmother had a cholecystostomy at the age of 18, and a cholecystectomy ten years later. Three of her sisters and a brother all had cholecystectomies for stones before the age of 30. Just to make the story complete, the maternal great grandmother had a cholecystectomy and the paternal great grandfather died at the age of 50 of jaundice—the cause unknown. During the preparation of this paper (August, 1957), the child's mother had a right oophorectomy and I am sorry to relate that palpation of the right upper quadrant revealed a thin-walled gallbladder that emptied readily; and, no stones were palpated. The child has a brother, age 8, two sisters, ages 3½ and 9, who apparently are free of gallbladder disease at the present.

In view of the patient's previous hospital admissions and the striking familial incidence of gallbladder disease, a cholecystogram and other pertinent laboratory studies to rule out congenital hemolytic anemia were done. The day after admission a cholecystogram revealed a poorly functioning gallbladder with many mottled areas suggestive of calculi. Another x-ray the following day revealed a similar picture and a diagnosis of chronic cholecystitis with cholelithiasis was made. Blood studies revealed a red blood cell count of 4,520,000; white blood cell count, 13,285 with a normal differential count; reticulocytes, 0.8 per cent; hematocrit, 41; sedimentation rate, 3 minutes; red blood count fragility, normal; the White coagulation time, 6 minutes; clot retraction, normal; prothrombin time, 100 per cent; van den Bergh's test, *direct,* was negative, and *indirect,* a normal of 0.1 mg. The thymol turbidity was 3.2 mg. per cent. Examination of the urine for albumin, sugar, acetone, bile, white blood cells, and urobilinogen was negative.

Because of the patient's symptoms, history, and roentgenologic and laboratory findings, an elective cholecystectomy was done on October 3, 1956. The gallbladder was rather long, had a pinkish-tan, smooth, shiny appearance, with a moderately thickened wall. Its lumen contained innumerable yellow faceted stones measuring from a few millimeters to about a centimeter in diameter. The mucosa was tan and finely granular. The liver appeared grossly normal. The spleen was not enlarged and appeared normal to palpation. Microscopic sections of the gallbladder showed the mucosal surface to be covered with columnar epithelium which was denuded in several areas. The submucosa showed evidence of fibrosis and a lymphocytic infiltration. The muscular layers were hypertrophied and there was an increase in interstitial fibrous tissue.

The child's postoperative course was uneventful and he was discharged on his sixth postoperative day. At the present time, 11 and one-half months following surgery, he is entirely asymptomatic.

CONCLUSIONS

Cholecystitis in childhood is not as uncommon as formerly believed. The clinician in considering a child with hepatitis, jaundice, or recurrent abdominal pain of obscure origin should consider the possibility of cholecystitis and cholelithiasis. When operating for appendicitis in a child and you find an "appendicitis apologans" and no other lower intestinal pathology, please palpate the right upper quadrant.

SUMMARY

A discussion of age, sex, and familial incidence of cholecystitis and cholelithiasis in childhood is presented. Emphasis is given to the comparison of the disease in the child to that of the adult in regard to etiology, symptomatology, pathology, and the surgical treatment. An operative case of chronic cholecystitis with cholelithiasis in a five-

year-old boy is presented. The hereditary predisposition to gallstone formation in the case is most striking.

ADDENDUM

At the time this paper is being published, the boy's sister, age 9, entered the hospital on June 4, 1958, complaining of vague epigastric distress, low grade fever, and occasional vomiting for the past two and one half months. A cholecystogram revealed fair concentration of the gallbladder with numerous tiny filling defects. A cholecystectomy was performed on June 12, 1958. The gallbladder presented the same gross and microscopic findings as did her five-year-old brother's gallbladder. Her postoperative course was uneventful and she was discharged on June 19, 1958.

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CHICAGO MEETING MISSISSIPPI VALLEY MEDICAL SOCIETY, SEPTEMBER 24–26

The 23rd Annual Meeting of the Mississippi Valley Medical Society will be held at the Hotel Morrison, Chicago, Sept. 24, 25, 26 under the presidency of Dr. Joseph C. Edwards of Washington University School of Medicine, St. Louis. The scientific papers by leading clinical teachers include: Dr. Gunnar Gundersen, President of the American Medical Association, Dr. Alton Oschner of Tulane University, Dr. Robert C. Hickey, Iowa State University, Dr. Mark H. Lepper, University of Illinois, etc., etc. There will be 6 panel discussions, the moderators and the subjects as follows: Panel on "Additional Helpful Procedures for Diagnosis and Prognosis in Jaundice and Liver Disease," Dr. James B. Carey, Mayo Clinic, Moderator; Panel on "Fractures in Children," Dr. John J. Fahey, formerly of the University of Illinois, Moderator; Panel on "Pulmonary Diseases," Dr. Paul Murphy, St. Louis University, Moderator; Panel on "Diarrhea in Infancy," Dr. Heyworth N. Sanford, University of Illinois, Moderator; Panel on "Hypertension", Dr. Peter J. Talso, Loyola University, Moderator; Panel on "Menopause, Menorrhagia and Amenorrhea", Dr. Robert B. Wilson, Mayo Clinic, Moderator.

There will be a big scientific and technical exhibit hall, a fellowship hour and banquet. All ethical physicians are cordially invited and urged to attend, the entire program being geared to especially appeal to those in general practice. The 15th annual meeting of the American Medical Writers' Association will be held in the same hotel on Sept. 26, 27. A complete program of either or both meetings may be obtained from Harold Swanberg, M.D., Secretary, W.C.U. Bldg., Quincy, Ill.

PUBLIC HEALTH SERVICE ORIENTATION FILM AVAILABLE

16-mm. filmograph, color, sound, 15 minutes. 1957.

Audience: Personnel in the health, medical, and allied professions.

This Public Health Service orientation film presents a panoramic view of the activities of the principal health agency of the Federal Government. Combining photographs and motion picture film, it shows the growth of the Public Health Service from its inception in 1798, with limited care of the sick and stranded merchant seamen, to its far-flung programs today in hospital and medical care, in medical and biological research, and in public health.

The film is available on a short-term loan from the Surgeon General, Public Health Service (P), Washington 25, D. C.

BIBLIOGRAPHY AVAILABLE ON STAPHYLOCOCCAL INFECTION

The National Library of Medicine has compiled a lengthy bibliography on staphylococcal infection, which, it is hoped, may be of value to both private and public health physicians who are engaged in combating the increased incidence of antibiotic resistant staphylococcal infection in the home, community, and hospital. The bibliography will be sent at no cost on request to: National Library of Medicine, Seventh Street and Independence Ave., S. W., Washington 25, D. C.

Clinical Significance of the Bleeding Nipple*

By KENDALL E. SAUTER, M. D.

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FOR many years sanguineous discharge of the nipple has been considered an ominous sign. A review of the literature during the past 30 years reveals considerable controversy and disagreement concerning its importance. As a result, we at Milwaukee County General Hospital Tumor Clinic were prompted to review and analyze our cases over the past few years to more properly evaluate this condition.

SYMPTOMS

Bleeding from the nipple is not a common sign (Chart 1) as Geschickter,[1] in 1945, noted bleeding in only 6.3 per cent of 2,917 benign breast lesions, and 4 per cent in 2,460 malignant lesions. In 1951, Fitts *et al.*[2] reported this sign in 9 per cent of 1,048 breast lesions at the University of Pennsylvania Hospital.

CHART 1—FREQUENCY OF BLEEDING FROM NIPPLE (GESCHICKTER[1])

Lesion	Number	Bleeding	Percentage
Cancer	2,460	102	4%
Benign	2,917	185	6.3%

The most common pathologic states producing nipple bleeding are:

1. Ductal papillomata, local (fig. 1) or diffuse (fig. 2).
2. Acinar hyperplastic changes with cystic degeneration and papillary dysplasia.
3. Intraductal or infiltrating ductal carcinoma.

Unusual causes include trauma, sarcoma, fibroadenoma, tuberculosis, inflammatory changes, and vicarious menstruation. In benign lesions the ductal epithelium may exhibit a wide variety of cellular changes, from papillary hyperplasia in a single ductal segment through diffuse papillary hyperplasia involving many ducts, to actual benign neoplasia in the form of a distinct papilloma.

DIAGNOSIS

In an attempt to make a diagnosis, the first and most obvious step is a search for a palpable tumor in the breast. This should be carried out with the patient undressed and

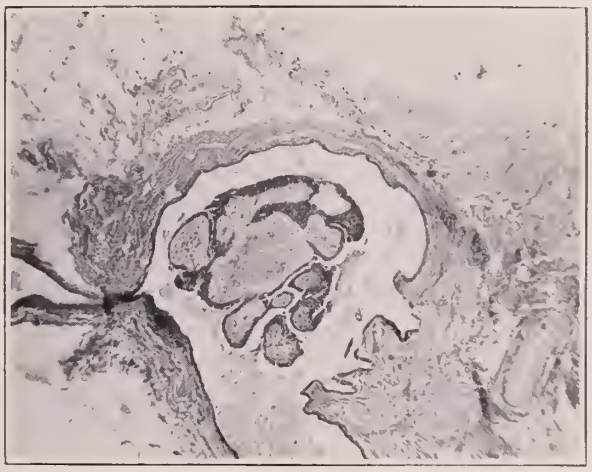

Fig. 1—Intraductal papilloma.

Fig. 2—Intraductal papillomatoses.

* Presented at meeting of the Wisconsin Surgical Society, Madison, September 20, 1957.

From Milwaukee County General Hospital Tumor Clinic and Marquette University School of Medicine, Milwaukee.

in both the upright and recumbent position. The examiner also should pay particular attention to the opposite breast, and supraclavicular and axillary regions. He should perform a complete physical examination and obtain x-rays of the chest and, many times, the lumbar spine. Fifty per cent of the time, one will find a mass in the central one-third of the breast. In its absence, the examination should be directed towards localization of the segment or duct from which bleeding originates. Close inspection of the nipple (if necessary, with a magnifying glass) will, at times, reveal a terminal duct opening containing dried blood.

The commonly utilized procedure of radial stroking of the breast, from the periphery toward the areola in a clockwise fashion, has been the most valuable method of localization in this clinic. In the absence of a palpable tumor most of the cases can be localized by this method.

In recent years Papanicolau smears of the discharge have been performed. Of the 8 cases in which this was done, only one was suspicious, showing atypical cells. This breast was later removed by simple mastectomy and studies revealed diffuse cystic disease. Much more valuable information was obtained by Jackson and Severance[3] on studies of cytological smears.

The use of transillumination may at times help visualize a thickening not apparent to the examining finger. It is an aid used in our examination.

X-ray mammography, consisting of injection of radio-opaque material into the ductal system, has resulted in some unfortunate complications according to medical literature. It was used in only one of our cases and was of no value.

TREATMENT

The physical findings generally result in a division of cases into one of three classes. The treatment will vary accordingly.

Group 1—This group includes those in which a palpable tumor is present. Here the therapy generally follows the same pattern as any other suspicious nodule in the breast; namely, biopsy and frozen section, followed by radical mastectomy if malignancy is present.

Group 2—This group includes those patients in whom no mass is present, but adequate localization is possible. In these instances a periareolar or radial incision has been our approach. A dilated, blood-filled duct or definite thickening is resected with a modest margin of normal tissue. A maneuver of considerable value has been the probing and insertion of the blunt end of the Keith needle into the duct and then placing the incision over the needle. If no definite pathology is detected a quadrant resection of the area of bleeding has been performed. Serial sections are then made by the pathologist.

Group 3—This group offers the most difficulty. The presence of bleeding without a palpable tumor and without localization presents a problem. Here the opinion of authorities differs markedly. Most contemporary writers have adopted a policy of watch and wait. It should be pointed out, however, that

Chart 2—Malignant Development in Bleeding Cases (Bloodgood[4])

Total Cases	68
Follow Up (3 to 7 Years)	57
Subsequent Carcinoma	5
Incidence	9%
Latent Period (Average)	34 Months
Average Age	52 Years

Bloodgood[4] (Chart 2) observed an incidence of carcinoma development of 9 per cent over a three-year follow-up. Some of these patients did have palpable tumors, however. The age of the patient is of some importance as the incidence of cancer with bleeding is higher in postmenopausal patients. In our clinic we have established the practice of following patients without palpable tumors and with bleeding from either one or both breasts until localization is present or bleeding stops. In only isolated instances, and not in recent years, has simple mastectomy been performed.

A glance at Chart 3 will show that since 1923 the incidence of carcinoma seems to be dropping, with one exception. Hollenberg,[5] in 1955, listed an incidence of 57 per cent.

Another point of interest is that in Gray and Wood's[6] series, 68 per cent were listed as grade one malignancy and only 25 per cent of 118 cases had pathologically proven lymph node involvement.

Haagensen's[7] series points up another interesting observation; namely, that 19 of 21 cases proven malignant had a palpable tumor.

Chart 3—Incidence of Carcinoma in Bleeding Nipple

Author	Year	Benign	Malignant	Total	Percent, Cancer
Miller, Lewis[9]					
Bleeding & Discharge	1923	12	28	40	68%
Adair[10]					
Bleeding Only	1930	57	51	108	47.2%
Hinchey[11]					
Bleeding & Discharge	1941	43	36	79	45%
Gray, Wood[6]					
Bleeding Only	1941	54	53	107	49%
Geschickter[1]					
Bleeding Only	1945	126	185	311	40%
Hollenberg[5]					
Bleeding Only	1955	27	17	44	57%
Haagensen[7]					
Bleeding & Discharge	1954	97	21	118	16%
Lewison[8]					
Bleeding Only	1955	46	8	54	14%

Chart 4—Summary: Bleeding Nipple Cases

Case No.	Age	Duration	Tumor	Pathology
1	73	8 Years	Yes	Cystic Disease
2	29	1 Week	No	Intraductal Papilloma
3	78	5 Months	No	Intraductal Papilloma
4	80	2 Weeks	Yes	Intraductal Papilloma
5	49	5 Months	No	Paget's Disease
6	67	2 Months	Yes	Mucoid Carcinoma
7	42	4 Weeks	Yes	Cystic Disease
8	42	None	Yes	Cystic Disease
9	53	4 Months	Yes	Scirrhous Carcinoma
10	78	1 Day	Yes	Cancer, Clinical Diagnosis
11	69	1 Month	Yes	Squamous Cell Cancer
12	53	2 Months	No	Intraductal Papilloma
13	65	2 Years	No	No Pathologic Diagnosis, Living and Well Jan. 10, 1956
14	22	3 Weeks	No	No Pathologic Diagnosis, Living and Well 1957 (Pregnant)
15	46	6 Months	Yes	Ductal Carcinoma
16	60	6 Months	Yes	Two Negative Biopsies
17	54	3 Months	No	Intraductal Papilloma
18	37	3 Months	Yes	Left Breast Adenocarcinoma
19	37	3 Months	Yes	Right Breast Cystic Disease
20	57	1 Month	Yes	Cystic Disease

Chart 5—Summary of Cases of Bleeding Nipples

18 Cases
20 Lesions
13 Benign 65%
7 Malignant 35%
7 Cases had Papanicolau Smears
6 Noncontributory
1 Atypical Cells, Simple Mastectomy, Cystic Disease
53 Years average age of benign cases.
57 Years average age of malignant cases.

The 18 cases reviewed in our clinic are shown in Chart 4. Chart 5 is a summary of these cases. There were 18 cases showing 20 lesions. Of these, 13 were benign, for an incidence of 65 per cent and 7 were malignant for an incidence of 35 per cent. Seven of these cases had Papanicolau smears performed. Six were negative and a seventh showed atypical changes. The average age for benign lesions was 53 years and for malignant lesions 57 years.

The types of surgery performed are summarized in Chart 6.

Chart 6—Operations Performed on Bleeding Cases

	None	Biopsy	Wedge	Simple	Radical
Benign	2	1*	6	4	0
Malignant	1	0	0	1	5

*Two biopsies showed no pathology.

That the handling of these cases is not always a simple matter is well illustrated by the following case. This 37-year-old female presented with bilateral nipple bleeding and multiple nodules. A fibroadenoma was removed from the left breast, but bleeding continued bilaterally. One nodule in the left breast began to enlarge and biopsy was urged. The patient resisted for a year and a half, at which time a carcinoma and associated cystic disease were present. A smear of the discharge from the right breast showed atypical cells and a simple mastectomy was performed. The pathologist reported cystic disease. The patient is living five years later, but with recurrent carcinoma.

In reviewing our material, many cases of bleeding from the breast were found. As far as we can determine, an obvious lesion such as a far-advanced (usually ulcerating) carcinoma was present. Obviously these cases have not been included in the present series. Their only problem was in differentiation from trauma or tuberculosis or infection.

It would also seem important to remember that nipple bleeding is not a diagnosis and, therefore, is not listed as a disease entity in the record room. As a result, it is logical to assume there may have been some benign cases which escaped detection because the bleeding ceased and the patient did not return. On the other hand, carcinoma with bleeding almost invariably ended in the hospital because of its natural tendency to progress.

SUMMARY

It is probably unwise to form definite conclusions for our small series; however, we wish to point out that in our experience of bleeding nipple cases a palpable tumor was present in 5 of the 6 cases eventually determined as carcinoma. This is in agreement with the two larger recently published series of Haagensen[7] and Lewison[8] and has led to a

more conservative approach to the whole problem of bleeding from the nipple.

324 East Wisconsin Avenue.

DISCUSSION

By C. Morrison Schroeder, M. D.

Doctor Sauter's review of the county hospital experience and of that of other investigators is a reminder that this symptom may very likely be evidence of a malignant condition and therefore requires careful investigation.

Fitts, *et al.*[2] (whom Doctor Sauter quoted) found that papillary proliferation of the ducts (papillomatosis) accounted for the discharge in 47 per cent of the cases, and that a solitary papilloma was present in only 5 out of the 46 cases in this category. For this reason they recommended excising a generous wedge of tissue with the duct divided at the nipple as the apex and extending to the periphery of the breast. They felt that locating and excising a single papilloma might be inadequate.

I agree that finding the duct from which blood exudes is helpful in locating the area to be excised. However, there is frequently only a small amount of blood or discharge present, and expressing the blood may empty the duct for several days. Therefore, I have asked members of the house staff to refrain from expressing secretion during their examinations the day before the operation, so that at operation this localizing maneuver will be useful.

Not infrequently I have had difficulty palpating masses immediately underlying the nipple, an area where many papillomas seem to occur. It requires special care on my part not to miss a tumor in this area.

On several occasions I have found discharge exuding from several ductal orifices or from different ones at the time of the original examination and at operation.

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INTERNATIONAL CONGRESS OF PSYCHOTHERAPY TO MEET SEPTEMBER 1–7 AT BARCELONA, SPAIN

The subject, psychotherapy and existential analysis, has been selected for the International Congress of Psychotherapy which will be held September 1–7, 1958, at Barcelona, Spain. The Congress Committee has chosen this subject because every day there is a more urgent necessity to confront it with other conceptions of the human being, and among those conceptions the most important without doubt, the Congress Committee says, is the one derived from KIERKEGAARD or the existential concept. The purpose of this Congress is to study all its eventual psychotherapeutical possibilities. The Congress Committee announces that, further to the General Assemblies, dedicated to the main theme, a great number of Special Sections about the most important and up-to-date psychotherapy questions has been foreseen.

Organization of the scientific work includes: psychotherapy from the point of view of cultural anthropology, influence of oriental psychology over present psychotherapy, clinical psychology, history of psychotherapy, psychoanalytic psychotherapy, psychodrama, group psychotherapy, child psychotherapy, hypnosis and relaxation methods, psychotherapy of the psychosomatic disorders, psychotherapy of psychoses, clinical psychiatry in front of the anthropological orientation, psychopharmacology and psychotherapy, psychotherapy and religion, psychotherapy and social work, and revision of the Schreber case.

Registration forms are available at the Journal office.

Home Safety Programs Show Results

As It Looks to Your State Board of Health

THE number of deaths due to home accidents in Wisconsin has shown a dramatic decline from the record high of 860 in 1948 to 528 in 1957. The improvement is even more impressive when the rate is considered; for if the 1948 rate had continued, almost 1,000 people would have died last year as a result of home accidents. The same downward trend is reported to be nationwide.

Obviously, something is being done about the prevention of fatal home accidents. Identifying that something and finding out what else is needed are the purposes of the home safety inventories conducted throughout the United States by the National Safety Council and in Wisconsin by the State Board of Health.

The last inventory report issued in 1957 showed that thousands of organizations have home safety as a part of their planned programs. In Wisconsin alone they included 26 different types, varying from parent-teacher groups, schools, and county extension services to public health departments, safety councils, Boy and Girl Scouts, and public utility companies. Through the efforts of these groups thousands of people are being reached with safety messages.

While most of the organizations reporting said they cooperated with one or more organizations at times, most programs were described as being an individual organization activity. When this section of the report is analyzed, there appear to be some interesting gaps in the over-all home safety work. For example, only 37 per cent reported any cooperation at all with "health, welfare, and medical groups." Only 25 per cent reported working with press, radio, or television, and only 6 per cent with home construction agencies whose people are constantly concerned with our home environment. Although no one noted serious problems, the need for coordination of the many activities is apparent if duplication of effort is to be avoided and the maximum number of people reached with safety information.

Another section of the last home safety inventory concerned program emphasis. Most organizations stated that their efforts were directed toward the "entire family." While such concern is commendable in theory, perhaps the time has come to consider whether such a diversified program is still the wisest way to use everyone's time and effort. Maybe some concentrated work is called for with the age groups where the home accident problems are still very great.

Each year about one-fifth of those who die as a result of home accidents are in the 0–4 year old age group and three-fifths are 65 or over. All others are scattered between the ages of 5 and 64. Similar proportions are reported yearly for the United States. The National Safety Council has found in sampling surveys that for each fatality there are about 150 injuries that disable the victims for one day or more. A recent study found accidents second in frequency to respiratory disease at all ages. Among disabling acute illnesses they are third. Thus, accidents are a major cause of illness, disability, and demand on medical facilities.

In spite of large numbers of accidental injuries and deaths among the very young and the older age groups, only 1.5 per cent of organizations reporting in the last home safety inventory stated that their main concern was with the preschool child and less than one per cent said they worked with the elderly. The group that is of most immediate concern to industry—the wage earners—was given special consideration by about four per cent. Perhaps some professional guidance is needed to direct attention of some of the lay groups to these areas of special need.

The 1958 home safety inventory will be carried out during the fall months. In addition to simple counting of how many are doing what things about home safety, an attempt will be made to evaluate how well home safety programs are meeting needs of the special groups mentioned above.

In the meantime, program aids are available from the State Board of Health as well as from the home safety committee of the Wisconsin Council of Safety. Stress is being placed on such things as:

1. *Education*—Safety needs to be taught at home, in school, and on the job. A number of Wisconsin industries are now working out home safety programs for their employees to help them apply successful industrial safety practices at home.
2. *Environment* — Removing hazards from the home is as important as removing them at the work place, school, or playground. Many of Wisconsin's builders are now stressing safety features in the new homes they build or those they remodel.
3. *Supervision*—Protection against dangers is needed for children, especially the preschool youngster and infants. Older adults also need special consideration. The use of bed rails, for example, or encouragement to use a cane may prevent serious accident.
4. *Community or Group Action*—A variety of programs can be carried on by men, women, or children's organizations to help each one learn the importance of taking appropriate action for his own safety. Local safety councils are encouraged to provide leadership.

The fact that the total number of home accidental deaths has gone down is encouraging because it suggests that our efforts in the past have been worthwhile. Now it is time to aim directly at the main problem areas to reduce the number still further.—LUIDA E. SANDERS, *Director, Division of Health Education.*

PREPARATION OF MANUSCRIPTS FOR THE WISCONSIN MEDICAL JOURNAL

Exclusive Publication: Articles are accepted for publication on condition that they are contributed solely to this Journal. Publication elsewhere will be subsequently authorized in the discretion of the Medical Editor.

Correspondence: Address all correspondence relating to publication of scientific papers to the Medical Editor, Box 1109, Madison 1, Wisconsin.

Manuscript: Type double spaced, on 20 pound white paper, 8½ by 11 with one inch margins at the top, bottom, and right, and 1½ inches on the left. Submit the original and two carbon copies. Use the metric system throughout. Call drugs by their generic names. The trade names can be added, in parenthesis, if they are considered important. Keep one copy of the paper.

Identification: Place the name of author and page number at the upper left-hand corner of each page except the first.

Footnotes and References: Use the style of the *Quarterly Cumulative Index Medicus* published by the American Medical Association, which requires, in the order given: name of author, title of article, name of periodical, with volume, pages, month—day of month if weekly—and year as follows:

4. Doe, J. E.: What I know about it,
Wis. Med. J. 54:717–719 (Dec.) 1954.

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Under ordinary circumstances articles are scheduled about six months in advance. The approximate date of publication, subject to change, will be given the contributor when the article has been accepted.

Society members throughout the state are encouraged to write up their interesting cases and submit them for publication. The editorial staff welcomes the opportunity of helping you prepare your article for the printer.

The Problem of Postanesthetic Hypoventilation

From the Wisconsin Anesthesia Study Commission of the Wisconsin Society of Anesthesiologists

By WILLIAM A. DOMANN, M. D.,* WILLIAM E. MATEICKA, M. D.,* and SHERWOOD W. GORENS, M. D.**

THE recent trend toward the use of combinations of several drugs and anesthetic agents, as opposed to the use of single agents used in the past to achieve desirable surgical conditions, occasionally results in complications in which a single etiologic factor is difficult to determine. The following two cases present the problem of postanesthetic hypoventilation.

CASE REPORTS

Case 1—A 42-year-old white male entered the hospital with a three-day history of abdominal cramping pain, nausea, and vomiting.

The general appearance was of a well-developed, dehydrated, acutely ill male. Blood pressure was unobtainable at the beginning of anesthesia and surgery, pulse 136, and temperature 104.4 F. The rest of the physical examination was essentially negative except for the abdomen, which was distended with guarding throughout, and the absence of bowel sounds. The initial laboratory studies revealed the hemoglobin to be 21 gm., hematocrit 63 per cent, nonprotein nitrogen 66 mg., sodium 133.4 mEq./l., chlorides 95.4 mEq./1., and potassium 4.16 mEq. /1. The flat plate revealed a small bowel obstruction. He was treated with fluids, plasma, blood, and intestinal suction.

Endotracheal anesthesia consisted of thiopental 0.4 per cent, succinylcholine 0.2 per cent, and nitrous oxide-oxygen with a semiclosed system and assisted respirations. Fluids, plasma, and blood were given during the procedure. Thirty minutes after induction the blood pressure was 130/70, pulse 130. Pulse and blood pressure stabilized at this level. One gram of neomycin with 50,000 units of bacitracin was instilled into the peritoneal cavity at the time of abdominal wound closure. To facilitate closure of the peritoneum, succinylcholine was used to produce relaxation. A total of 400 mg. of thiopental and 800 mg. succinylcholine was used throughout the two-hour procedure. The patient tolerated the procedure well. At the termination of the two-hour procedure spontaneous respirations were present, but there was a marked reduction in tidal volume. The treatment consisted of manually assisting respirations for the following four hours. Respiration at this time was adequate and the patient was extubated. There were no other anesthetic complications.

Case 2—A 77-year-old white retired baker was transferred to the surgical service with the diagnosis of large bowel obstruction. The same day a transverse colostomy was done to relieve the obstruction, and adenocarcinoma of the rectum was found. Anesthesia was uneventful. An anterior resection was done one month later. Approximately three weeks later this patient had a closure of his colostomy. The conduct of anesthesia was without incident and the patient was awake at the end of the procedure. The patient had progressive abdominal distention and six days later he was returned to the operating room and an anastomotic obstruction was found and repaired. Prior to closure of the peritoneal cavity, 1 gm. of neomycin with 50,000 units of bacitracin was instilled into the abdominal cavity. To facilitate closure of the peritoneum, succinylcholine was used to produce relaxation. Endotracheal anesthesia consisted of 0.4 per cent thiopental, 0.2 per cent succinylcholine, and nitrous oxide-oxygen with a semiclosed system and assisted respirations. A total of 800 mg. of thiopental and 800 mg. succinylcholine were used for the 3½-hour procedure. The respirations at the termination of the procedure were markedly depressed. The tidal exchange was inadequate and the respirations were assisted for the next four hours. Respiration was adequate at this time and the patient was ex-

* Residents in anesthesiology at Veterans Hospital, Wood, Wisconsin.
** Chief, anesthesiology at Veterans Hospital, Wood, Wisconsin.

tubated. No other anesthetic complications were encountered and the patient made an uneventful recovery.

DISCUSSION

In a discussion as to the etiology of hypoventilation and/or apnea in these two cases during anesthesia, or postanesthesia, thiopental must be considered as a causative agent. The thiobarbiturates are known potent central depressants of respirations. Depending on the amount and rate of injection, a momentary apnea may be produced in 30 to 40 seconds after the injection of a moderate dose. Respirations are usually resumed with a reduction in tidal volume. There may be no change in rate. Even a sleep dose of thiopental depresses respiratory minute volume by 22 per cent.[1]

Premedication and the amount of surgical pain affect the depth of respiration. This is a very important fact to remember at the termination of a case because a patient may be breathing satisfactorily in the operating room, but when taken to the recovery room or ward and left undisturbed, severe respiratory depression may occur. Assisted respiration is the obvious treatment until adequate spontaneous respiration returns.

With the widespread use of muscle relaxants in clinical anesthesia practice, the incidence of prolonged postanesthetic apnea and/or hypoventilation has increased.[2]

With regard to the depolarizing agents such as succinylcholine, the simplest cause of prolonged postoperative apnea is overdosage of the drug with failure of the anesthetist to "back-titrate" the apneic patient to the point of at least feeble inspiratory efforts as seen by slight excursions of the breathing bag. The short duration of action of succinylcholine is due to its rapid destruction by plasma cholinesterase.

Another cause of prolonged apnea following the use of depolarizing agents is the presence of low serum cholinesterase levels which are frequently present in widespread liver disease. Also, succinyldicholine is broken down in succinylmonocholine and choline. Succinylmonocholine has about one-eighth the activity of the dicholine and its rate of hydrolysis is six to eight times slower. Theoretically then, it is possible that succinylmonocholine is capable of producing muscular paralysis in its own right, although this is unlikely unless more than 1 to 2 gm. are used.

The phenomenon of dual block which may occur after prolonged or repeated dosages of a depolarizing agent such as succinylcholine is of more than academic interest to anesthesiologists because it is probably second only to overdosage as a cause for prolonged apnea after anesthesia in which this agent is used. Briefly, the mechanism of a dual block is one in which the depolarizing drug first brings about depolarization of the motor end plate by virtue of its affinity for the protein molecules of the end plate receptor. Then the protein molecules of the end plate change so that they respond to the succinylcholine (depolarizing agent) in a manner similar to a nondepolarizing drug, *i.e.*, curare, in that they merely adhere to the end plate, but do not cause further depolarization. One can see that the drug (succinylcholine) itself does not cause this alteration, but rather it is the manner in which the end plate protein molecules respond to the drug.[3]

If a dual block is suspected, the course of action is to give an ultra short anticholinesterase drug such as edrophonium, 10 mg. If the neuromuscular block or hypopnea increases, then a depolarization block is present, *i.e.* overdose of depolarizing agent. If marked improvement occurs, a dual block is present.

Other factors responsible for prolonged apnea are a mild alkalosis resulting from hyperventilation by means of controlled respirations with carbon dioxide absorption and acidosis due to underventilation which leads to carbon dioxide narcosis. It has recently been reported that certain patients, especially the elderly, dehydrated patient with intestinal obstruction, will underventilate or fail to breathe postoperatively. In such cases the neuromuscular block produced by a nondepolarizing agent such as d-tubocurarine is not reversed by administration of neostigmine. It is felt that in such a situation there is a low intracellular potassium concentration and the d-tubocurarine actually passes into the nerve cells in the brain and depresses them directly.

Lastly, during the past year an increasing number of reports in the literature have incriminated the intraperitoneal administration of neomycin sulfate as a cause of severe respiratory depression during and after anesthesia.[4] The fact that neomycin sulfate is a neuromuscular blocking agent of the nondepolarizing type has been well established.

In fact, the minimum lethal dose of this drug is determined in rats by finding the smallest amount which, when injected intraperitoneally, will cause death by respiratory paralysis. Because ether is a neuromuscular blocking agent of the nondepolarizing type, this same pharmacologic effect of neomycin sulfate is potentiated by the simultaneous administration of the two drugs. The intraperitoneal route of parenteral administration of drugs affords rapid absorption, especially from an irritated membrane as is found in intestinal obstruction or peritonitis. The onset of neuromuscular blockade of neomycin sulfate administered intraperitoneally is about 20 to 30 minutes and the more concentrated the solution (1 gm./100 cc.), the greater the probability of absorption and paralysis.

Treatment of neomycin-produced respiratory depression is best carried out by continuing artificial respiration as long as necessary, and by administering an anticholinesterase drug such as edrophonium or neostigmine methyl sulfate.

The problem of postanesthetic hypoventilation or apnea requires a critical review and analysis of the multiple factors which may be responsible, and institution of the appropriate therapy as determined by etiology. At all times, assisted or controlled respirations should be instituted until adequate spontaneous respiration returns.

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AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY, INC.

Applications for certification (American Board of Obstetrics and Gynecology), new and reopened, Part I, and requests for re-examination Part II, are now being accepted. Deadline date for receipt of all such applications is September 1 , 1958. No applications can be accepted after that time.

The members of the American Board of Obstetrics and Gynecology wish to announce that at the recent final examinations for certification, the total of 280 certifications out of a group of 383 candidates examined.

Wisconsin physicians certified in this specialty at the recent examinations are: Donald J. Albrecht, Milwaukee; Richard C. Brown, Eau Claire; William J. Buggy, Milwaukee; John R. Healy, Madison; Stanley A. Korducki, Milwaukee; Leonard J. McKenzie, Madison; and James P. Pauly, La Crosse.

It is expected that the new Bulletin of the American Board of Obstetrics and Gynecology will be available some time during the month of July. A copy of this booklet may be obtained by writing to the office of the Secretary, Robert L. Faulkner, M. D., 2105 Adelbert Road, Cleveland 6, Ohio.

AMA PRODUCES NEW FILM ON FOOD QUACKERY

How modern "medicine men" dupe the public into spending millions of dollars on unnecessary or overpriced nutritional products is the story unfolded in a new American Medical Association film. Prepared especially for airing over local television stations under the auspices of local medical societies, this new 27-minute film—"The Medicine Man"—dramatically pinpoints the fight against quackery in the food and nutrition field.

The film singles out problems which stem from health lecturers who travel from town to town giving misinformation on nutrition as a tie-in to plugging their products of questionable merit and from door-to-door salesmen who misrepresent the value of nutritional products. The film also shows how the medical profession cooperates with the Food and Drug Administration and voluntary agencies such as the National Better Business Bureau in the crackdown on these food quacks.

First showing of the film will be at the AMA's Public Relations Institute August 27–28 at the Drake Hotel, Chicago. Prints will be available to local medical societies after September 15 from the AMA TV Film Library.

. . . . THE PRESIDENT'S PAGE . . . .

Model of Statesmanship

LAST June 30 saw the end of another fiscal year. The next day began a new year in the business sense. For William D. Stovall, M. D., those two days in mid-1958 marked a somewhat analagous situation. While June 30 was to have marked Doctor Stovall's retirement as director of the State Laboratory of Hygiene and professor of clinical pathology at the University of Wisconsin Medical School, he continues on until a successor is found.

Shortly before the end of Doctor Stovall's term, as in the accounting field, the auditors came in to balance the books. In his case, the auditors were his friends and colleagues among the medical profession and the public with whom and for whom he has labored so diligently lo these many years. Under the auspices of the Dane County Medical Society and its Woman's Auxiliary, these friends of Doctor Stovall surveyed his record and spread it out for all to see.

The result was undoubtedly the finest acknowledgment of a man's devotion, courage and selflessness that I have ever witnessed. Each of those who spoke, and many who did not, either orally or mentally toted up the handsome figures of his contributions to health in Wisconsin. But, like most statistics, this impressive tabulation did not tell the whole story.

Physicians in private practice are wont to look with a somewhat jaundiced eye upon the physician in public office or public health. Yet, no physician can deny that Doctor Stovall has always had uppermost in his mind the welfare of the patient *and* the private practitioner.

There are many among whom ivory-towered smugness is symbolical of the teacher, yet all can attest that compassion ruled over cold calculation in any of Doctor Stovall's dealings with people.

There are some who regard the laboratory researcher as either an "egghead" or a "dreamy-eyed bug chaser." I hope that Wisconsin generations yet to come will realize that they owe a great deal of their life and enjoyable living to Doctor Stovall's persistent search for improved physical and mental well-being.

These are all ways of saying that Doctor Stovall was, and is, the profession's finest model of medical statesmanship. His is an accounting of stewardship which we hope many others will attempt to emulate.

As one might expect, June 30 did not close the books for Doctor Stovall. It merely marked the beginning of a new chapter of a highly worthwhile life. We wish him well and long, continued happiness.

Jerome W. Fons M.D.

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EDITORIAL COMMENT

ANTIBIOTICS—A Two Edge Sword

The recent survey made by Welsch, Lewis Weinstein, and Bechmann of 800 hospitals, and interviews with more than 1600 physicians, some of whom were from Wisconsin, turned up some interesting reactions to the antibiotics. Penicillin was found to produce the greatest number and the most severe reaction of all the antibiotics presently available. They encountered a total of just over 2,500 penicillin reactions, of which 901 were considered life threatening, and these resulted in fatality rates of 9 per cent. The vast majority of reactions to penicillin were due to intramuscular administration.

The next most important severe reactions classified were superinfections, and of these enterocolitis was the most frequent. This had a mortality rate of 34 per cent. The total number of cases in this group was 107. Then they covered 16 cases of blood dyscrasia due to chloramphenicol, and here again the death rate was high. Of the total 27 cases due to all drugs, 23 were fatal. The most frequently occurring minor-nonlife threatening reaction to antibiotics was angioneurotic edema and urticaria. The broad spectrum antibiotics caused relatively few adverse reactions, most of which were classified as not severe.

This survey re-emphasizes the need for care and administration of antibiotic drugs.

A study of case histories does not reveal an indiscriminate use of penicillin by physicians, but rather the expected increase of incidence of reactions through wide use of highly antigenic substance. Insofar as the tetracycline antibiotics are concerned, it is obvious that they should be used cautiously and judiciously, particularly in patients undergoing an abdominal operation. The possibility of staphylococcal enterocolitis must always be kept in mind when these drugs are given.

This survey points up the fact that all drugs have side effects and complications, and their indiscriminate use is to be abhored. Antibiotics in particular should be used only when indicated, and their use curtailed, when the desired effect has been produced.

The Role of the Medical Profession in Eye Care

Many physicians are in doubt and have expressed concern at the misunderstanding and confusion of the public regarding eye care. Very little attention has been given by medicine in the past to the subject of public education relating to medical eye care.

The National Medical Foundation for Eye Care was organized by nationally recognized leaders in ophthalmology and is supported by American ophthalmologists for the purpose of gathering, studying and disseminating information to the medical profession and the public concerning the essentials of scientific eye care. The Foundation will prepare literature and lectures for the public explaining the basic scientific standards of good medical eye care, the qualifications of ophthalmologists and the training and functions of related technical personnel in the field of ocular therapy.

It should be emphasized that it is not the purpose of the Foundation to curtail the activities of licensed optometrists in the field of eye examination for the purpose of prescribing and fitting glasses, either by legislation or publicity.

It is unfortunate, however, that there should exist so much misunderstanding in the public mind concerning the terms ophthalmologist, optician, and optometrist. For a better understanding of these terms the National Medical Foundation for Eye Care published a pamphlet of definitions (free copies available upon request) which is quoted as follows:

An ophthalmologist is a physician—a Doctor of Medicine—who specializes in the care of the eye and all the related structures. He diagnoses and treats defects of focus, disorders of function, and all other diseases of the eye, prescribing whatever is required, including glasses. He is often concerned, as a consultant member of the medical team, with diseases of other systems of the body or general diseases which manifest themselves in the eyes—diabetes, toxemia of pregnancy, cancer, multiple sclerosis, tuberculosis and other infections, hypertension, muscular dystrophy, brain tumor and heart disease, among others. Ophthalmology is a branch of medicine and the ophthalmologist is an eye physician and usually also an eye surgeon.

An ophthalmologist has first completed the full course of medical studies, received the degree of M. D., (Doctor of Medicine), served an internship in general medicine and surgery in an approved hospital, and has then taken special training in ophthalmology. Like the family physician, the ophthalmologist and all other medical specialists are licensed to practice all branches of medicine and surgery.

Oculist is a less commonly used name for ophthalmologist.

An optician is a skilled technician, auxiliary to medicine, who supplies and fits glasses on the prescription of a physician. He is trained to make the necessary facial measurements; to formulate the specifications necessary and to make the glasses or other appliances; and to adapt them to the patient, placing them properly in relation to the eyes. He supplies glasses or other appliances only on the doctor's authorization.

An optometrist is a person who has met certain legal and educational requirements and is licensed by the state to engage in the practice of optometry. He is *not* a physician or doctor of medicine. The word optometry comes from two Greek words—opto, meaning "'eye" and meter, "measure." The optometrist measures the focus of the eye for glasses. He is not qualified or permitted to use drugs for these tests or for any other purpose. He is not qualified or permitted to diagnose or to treat ocular disease. He may supply glasses on his own prescription. In most states he is also permitted, like the optician, to fill the ophthalmologist's prescription for glasses.

Early diagnosis in cases of defective vision is of the utmost importance if we are to achieve the ultimate objective—"Prevention of Blindness." This can only be accomplished by helping the general public and the medical profession to understand the basic professional and scientific standards of good eye care.

Every child should have a medical eye examination before starting school. This is just as important, and in our considered opinion more important, than the generally accepted dental examination, both, however, being absolutely essential for the child's future welfare.

Every adult after the age of thirty-five should have periodic medical eye examinations to rule out such blinding conditions as glaucoma (the greatest cause of blindness in middle age, occurring in two per cent of adults over the age of forty), retinal disease, cataracts, etc.—*Reprinted from the Cincinnati Journal of Medicine, March, 1958.*

MID-WEST FORUM ON ALLERGY TO MEET DECEMBER 6–7 AT DETROIT

The Mid-West Forum on Allergy will hold its annual meeting on December 6 and 7, 1958, at the Sheraton-Cadillac Hotel, Detroit, Michigan. This meeting of the Forum is sponsored by the Michigan Allergy Society. For further information please write to John M. Sheldon, M.D., General Chairman, in care of the University Hospital, Ann Arbor, Michigan.

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REFERENCES: (1) Schneierson, S. S.: *J. Mt. Sinai Hosp.* 25:52, 1958. (2) Waisbren, B. A.: *Wisconsin M. J.* 57:89, 1958. (3) Ritts, R. E., Jr.; Mao, F. H., & Favour, C. B.,in Weleh, H., & Marti-Ibanez, F.: Antibiotics Annual 1957-1958, New York, Medical Encyelopedia, Inc., 1958, p. 774. (4) Rhoads, P. S.: *Postgrad. Med.* 21:563, 1957. (5) Roy, T. E.; Collins, A. M.; Craig, G., & Duncan, I. B. R.: *Canad. M.A.J.* 77:844, 1957. (6) Hasenelever, H. F.: *J. Iowa M. Soe.* 47:136, 1957. (7) Holloway, W. J., & Scott, E. G.: *Delaware M. J.* 29:159, 1957. (8) Waisbren, B. A., & Strelitzer, C. L.: *Arch. Int. Med.* 99:744, 1957. (9) Derham, R. J., & Rogerson, M. M.: *J. Dis. Child.* 93:113, 1957. (10) Murphy, J. J., & Rattner, W. H.: *J.A.M.A.* 166:616, 1958. (11) Rabe, E. F.: *Pennsylvania M. J.* 61:209, 1958. (12) Rosenthal, I. M.: *GP* 17:77 (March) 1958.

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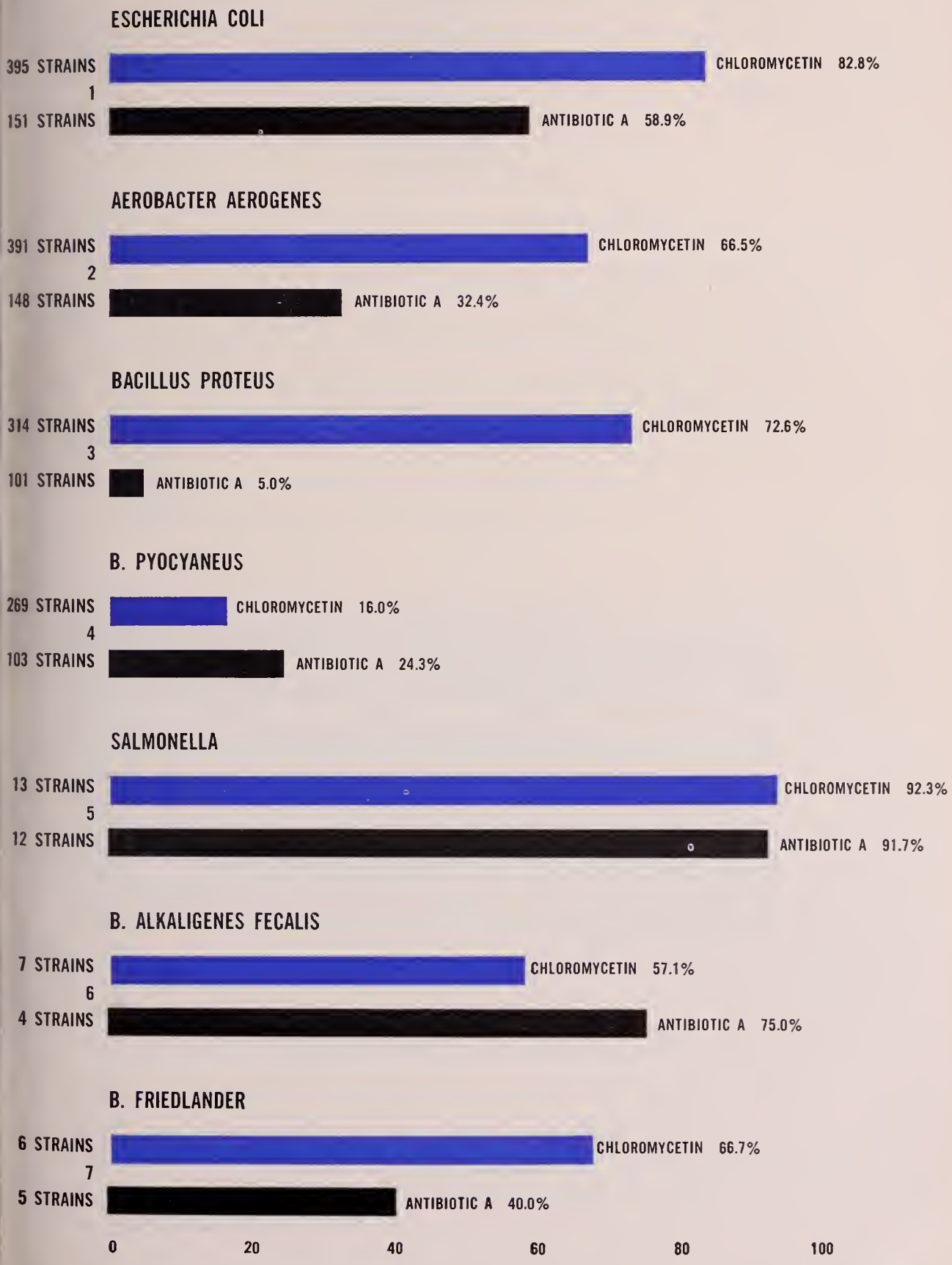

*Adapted from Schneierson.[3]

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FORMULA	OZ.	TOTAL CALORIES	CARB. CAL.	FAT CAL.	PROT. CAL.
Whole milk	24	480	5%	36%	14%
Water	22	—	—	—	—
Karo Syrup	1½	180	45%	—	—

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Karo Syrup	1½	180	45%	—	—

An infant will usually take 2 to 3 ounces more than his *age in months* at 3 to 4 hour intervals to satisfy his appetite and nutritional needs. It is psychologically unwise to force prescribed amounts. Normally, the gain in weight of 6 to 8 ounces a week during the earlier months gradually diminishes to 3 to 4 ounces a week by the end of the first year. The standard one-formula mixture not only provides adequate nutrition when vitamin supplements are added; it also provides educational opportunities to prevent feeding problems.

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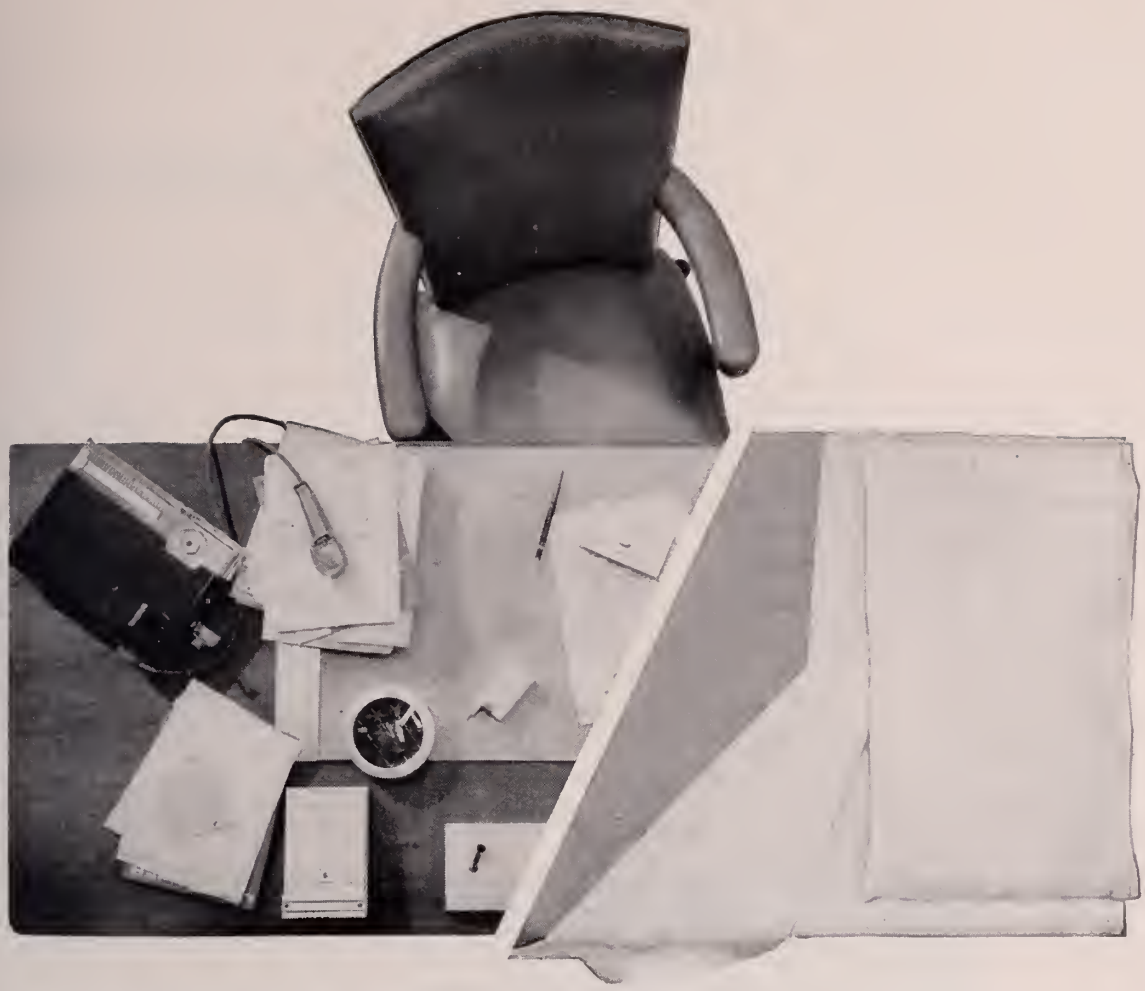

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Wilkins, R. W.: New England J. Med. **257:1026**, Nov. 21, 1957.

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Freis, E. D., Wanko, A., Wilson, I. H. and Parrish, A. E.: J.A.M.A. **166:137**, Jan. 11, 1958.

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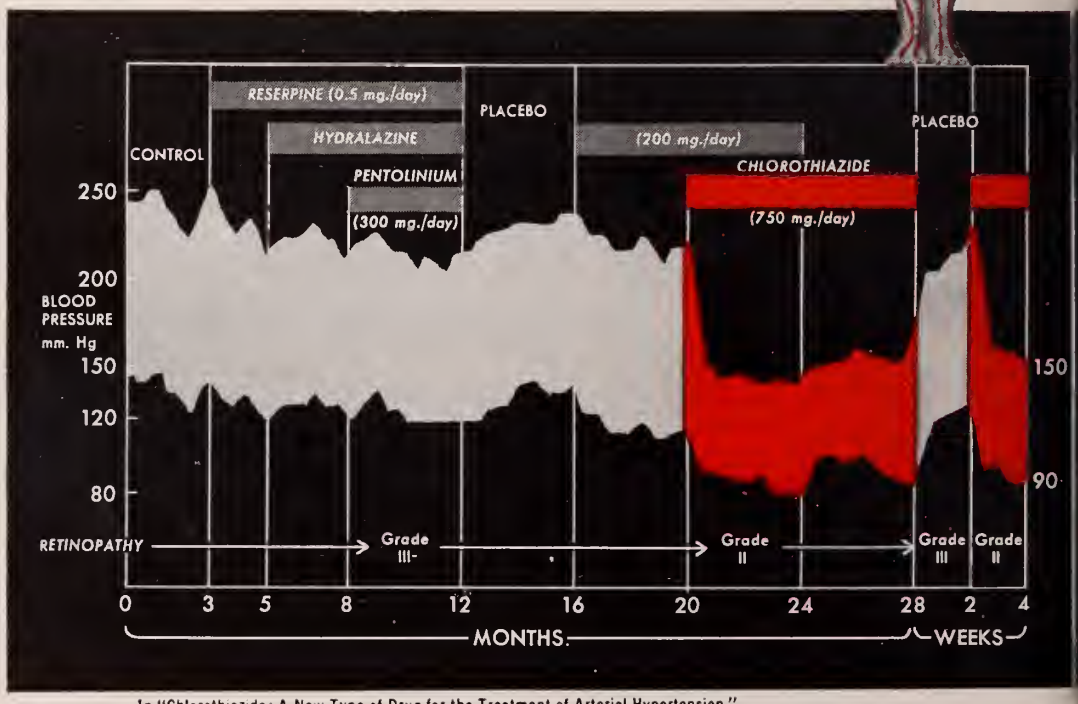

In "Chlorothiazide: A New Type of Drug for the Treatment of Arterial Hypertension," Hollander, W. and Wilkins, R. W.: Boston Med. Quart. **8:1**, September, 1957.

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references:

1 Grieble, H.G., and Jackson, G.G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958

2. Editorial: *New England J. Med.* 258:48-49, 1958.

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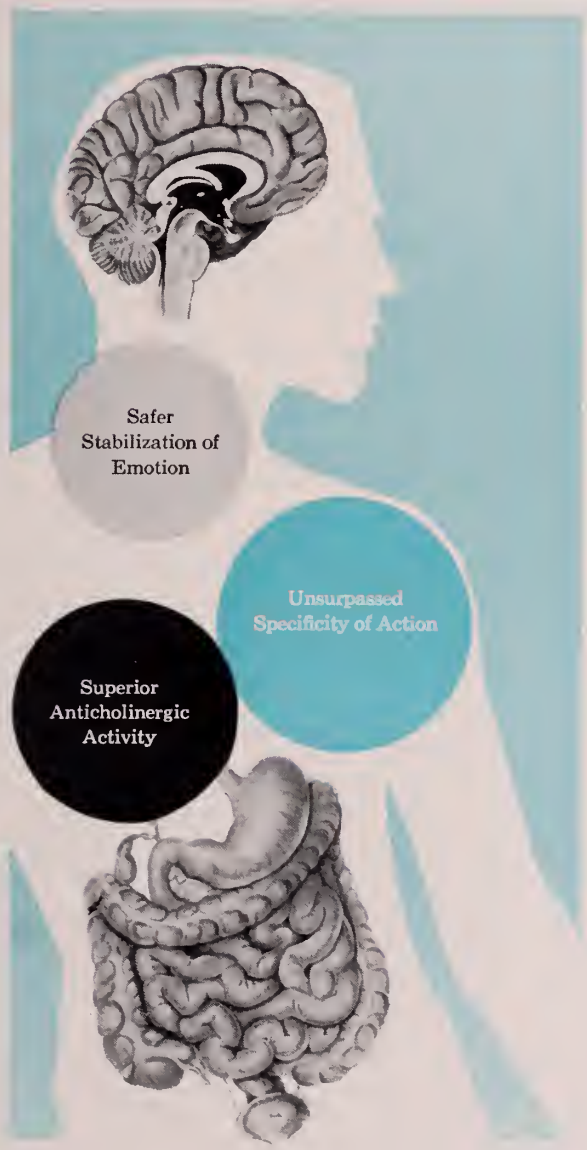

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EDITORIAL COMMENT

Why People Bought Life Insurance

A recent survey of members of 3,000 spending units sampled in a continuing study by the Survey Research Center of the University of Michigan in cooperation with the Board of Governors of the Federal Reserve System indicates that life insurance is purchased for many reasons.[1] Whereas only 12% mentioned insurance as a good method of saving, 35% gave as one reason for paying premiums the establishment of a "clean-up" fund to pay outstanding bills, debts, and funeral expenses. Provision for paying the costs of the last illness is given by life insurance salesmen as one of the major reasons for buying life insurance, and this survey of persons who had purchased life insurance and continued to pay premiums thereon verifies the appeal of this familiar sales argument.

The rapid growth of voluntary health insurance has tended to obscure this time-honored role of life insurance in defraying the cost of the last illness. More than one billion dollars a year is paid out by life insurance companies for death claims of persons aged 65 and over, the age group which experiences the highest mortality rates. The funds made available through life insurance for paying medical and hospital debts for the last illness are just as useful to the surviving members of the family as are the payments made under health insurance policies. One cannot, of course, know which illness or accident will be the last, but the last one is typically the most expensive. This survey also indicates that the proportion of persons in the age group 65 and over owning life insurance increased from 52% in 1950 to 56% in 1956.

Whereas only 18% of the spending units with incomes of $7,500 or more mentioned the provision of a "clean-up" fund as one of the basic reasons for purchasing insurance, 65% of those with earnings of less than $2,000 a year were motivated in part by the desire to provide such a fund. Moreover, it is likely that many respondents who gave "to provide for dependents" as one of the reasons for buying life insurance could have had in mind the advantage to dependents of providing for the payment of debts outstanding at the time of death.

[1] Miner, J. L.: Life Insurance Ownership Among American Families, 1957, Ann Arbor, Mich., University of Michigan, 1958.

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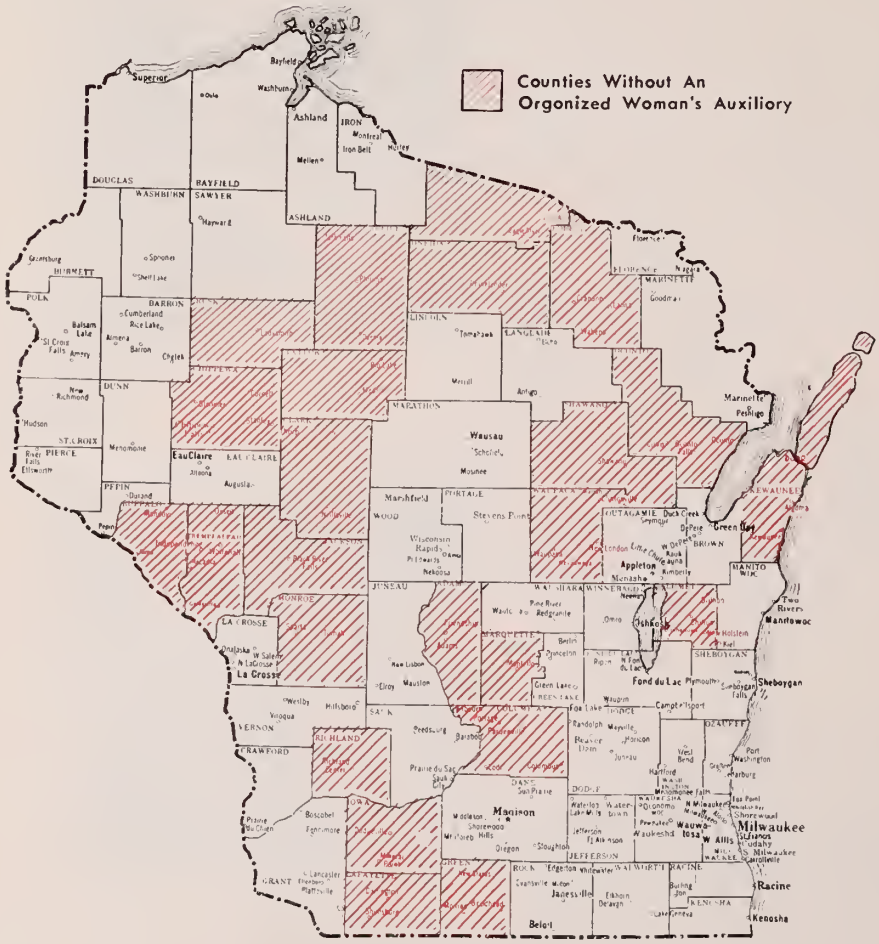
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Society Proceedings*

Brown

A special meeting of the Brown County Medical Society was held on the evening of June 26 at Bellin Memorial Hospital in Green Bay. The latest developments of the Wisconsin Physicians Service Blue Shield Plan and the Blue Cross Plan were reviewed by the group.

Pierce–St. Croix

The Pierce–St. Croix County Medical Society held its monthly meeting on July 15. *Dr. O. H. Epley* provided his cottage on Half Moon Lake for the occasion.

Polk

Twenty-six members of the Polk County Medical Society met July 17 at Paradise Lodge in Balsam Lake as dinner guests of *Dr. Fred Whitlark* of Amery.

Guests and speakers on an open forum were: *Drs. Howard Pagel*, Ladysmith; *Maurice Whalen*, Bruce; *Rex Graber*, Chippewa Falls; and Senator Holger Rasmusen, Spooner. Following the panel discussion *Dr. Fred Riegel* reported on the availability of a 200-bed Civil Defense hospital which is stored in the county.

Shawano

On June 25 the Shawano County Medical Society met to set up plans of coordination with civil defense units in event of emergencies or disasters in that area. Among points discussed were the appointments of each doctor to special stations in the area and the designation of special receiving stations. Heading the program was *Dr. A. J. Sebesta* who also reported on a recent Madison meeting on Streptococcus infection.

Trempealeau–Jackson–Buffalo

Dr. John Skemp, La Crosse, presented a paper on "Problems in Vaginal Bleeding during Pregnancy"

* Physicians whose names are printed in italics are members of the Society.

at the June 24 meeting of the Trempealeau–Jackson–Buffalo County Medical Society. The meeting, held at Club Midway in Independence, also featured a delegate's report on the sessions of the House of Delegates at the Annual Meeting. During the business meeting the members unanimously approved the action of the State Medical Society in its plan to furnish hospital and health insurance to residents of the state.

Washington–Ozaukee

The Washington–Ozaukee County Medical Society held its June 26 meeting at the Linden Inn at Slinger. *Dr. William Frackelton* of Milwaukee gave an illustrated lecture on traumata which included fractures to the face. Twenty-five physicians and their wives attended.

The next meeting will be held September 25. This meeting will be held jointly with members of the Washington–Ozaukee Legal Society. Judge Milton Meister and state legislators from this district will discuss mutual problems.

Milwaukee Neuro–Psychiatric Society

On May 21 the Milwaukee Neuro–Psychiatric Society convened for its annual meeting and election of officers. Those selected for the year 1958–59 are as follows: *Dr. E. C. Schmidt*, president; *Dr. Bernhard Kaufman*, vice-president; *Dr. Henry Veit*, secretary-treasurer; and councillors remaining, *Drs. David Cleveland* and *Isaac Sarfatty*.

Wisconsin Psychiatric Association

A meeting of the Wisconsin Psychiatric Association was held June 6 at the Top Hat Restaurant in Middleton. The Association heard the report of its delegates to the Assembly of District Branches at the American Psychiatric Association meeting in San Francisco in May.

Guest at the meeting was Dr. David Rioch, Director of Research at the Walter Reed Army Medical Center in Washington, D. C. He spoke on research currently being done at the Center using monkeys and testing responses to epinephrine and norepinephrine in different forms of psychic stress. He touched upon problems of psychosomatic complications in the different animals.

Wisconsin Society of Pathologists

A scientific program was held in the Mary E. Sawyer Auditorium in La Crosse on June 7 by the Wisconsin Society of Pathologists. Drs. *Paul Dietz* and *James L. Jaeck*, both of La Crosse, were hosts to the assembly.

Dr. Gunnar Gundersen presented the welcome address and scientific papers were given by *Drs. J. L. Jaeck;* D. R. Mathieson of the University of Minnesota Mayo Foundation; *S. E. Sivertson*, Gundersen Clinic; E. B. Flink, University of Minnesota V.A. Hospital; J. B. Miale, Universtiy of Miami and director of clinical pathology at Jackson Memorial Hospital, Miami; and H. B. Harding, Northwestern University.

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Wisconsin Surgical Club

Members of the Wisconsin Surgical Club met June 21 at Luther Hospital, Eau Claire, Wisconsin. Those attending in addition to the program speakers were: *Drs. Norman O. Becker,* Fond du Lac; *Warner S. Bump,* Rhinelander; *Conde F. Conroy, Carl W. Eberbach, Joseph M. King,* and *C. Morrison Schroeder,* Milwaukee; *L. D. Graber,* Oshkosh; *Sigurd B. Gundersen,* La Crosse; *Arnold S. Jackson* and *Erwin R. Schmidt,* Madison; *Jack Killins,* Green Bay; *Russell M. Kurten,* Racine; *Victor F. Marshall,* Appleton; and *M. G. Rice,* Stevens Point.

Subjects presented by Eau Claire physicians were as follows: "Experiences with the Bancroft Operation for Duodenal Ulcer", by *Dr. P. A. Midelfart;* "Carcinoma of the Cervix In situ; Diagnosis and Surgical Therapy", by *Dr. R. C. Brown;* "Leiomyoma of the Small Bowel with Report of Three Unusual Cases", by *Dr. F. G. Anderson;* "Judet Hip Prosthesis, Fifty Cases", by *Dr. C. M. Ihle;* "Pseudomembranous Entercolitis", by *Dr. D. M. Willison;* "Hypotension During Anesthesia", by *Dr. H. E. Thimke;* "The Value of Electrophoresis in the Study of Serum Proteins", by *Dr. H. J. Conlon;* "Urinary Amylase Excretion in the Diagnosis of Pancreatitis", by *Dr. P. A. Midelfart.*

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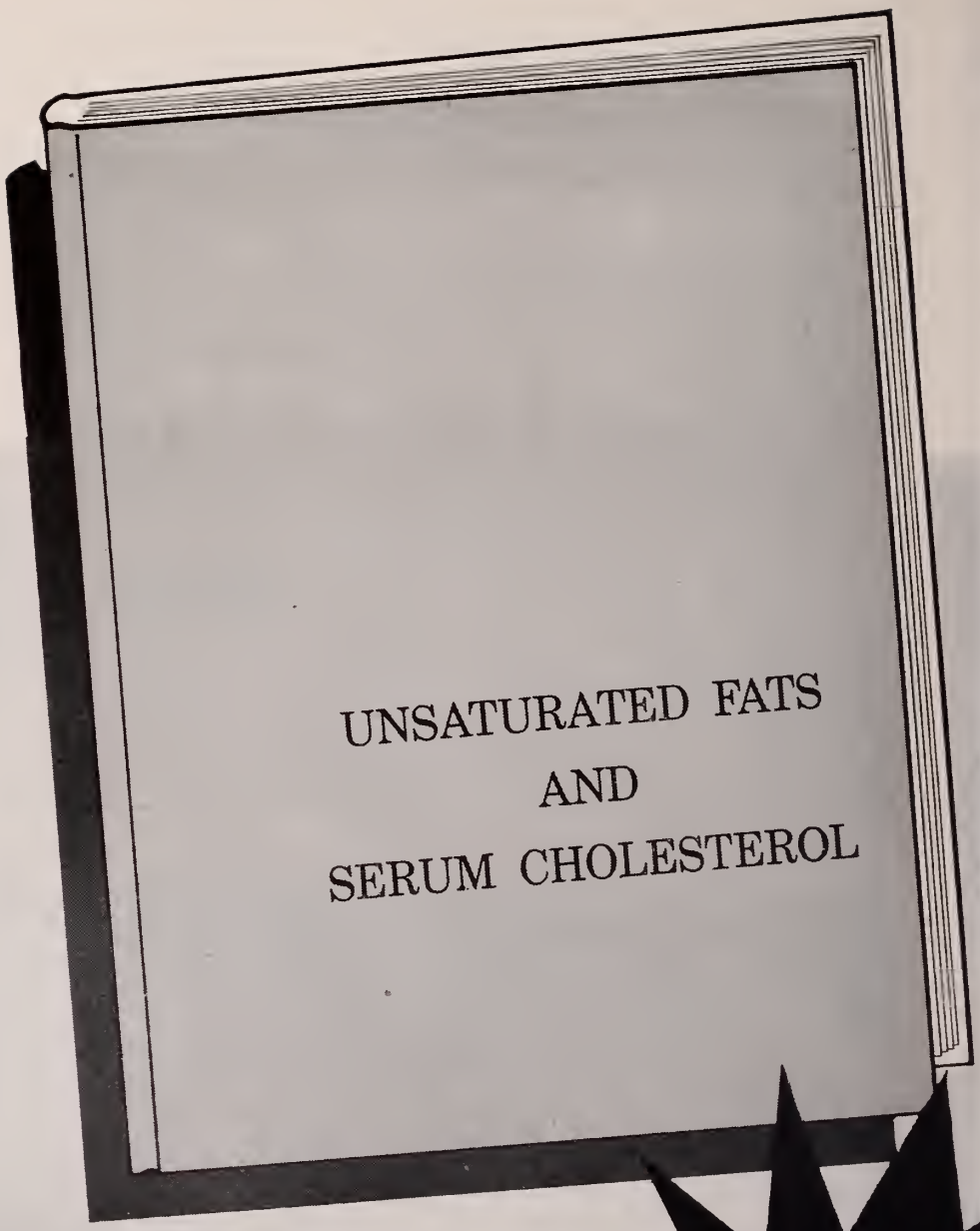

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THE MEDICAL FORUM

AMA TO PUBLISH NEW NEWSPAPER, THE AMA NEWS

HEALTH COVERAGE AT NEW HIGH

NEW YORK—The Health Insurance Council reported recently that the number of Wisconsin residents covered by voluntary health insurance has reached a new high. More than 2,794,000 persons are now protected by some form of insurance designed to help pay doctor and hospital bills.

The national total is now 123,000,000, or 72 per cent of the entire U. S. population.

The 1956 year-end total in Wisconsin was 2,592,000.

The number of Wisconsin residents with surgical care insurance, which helps to defray the cost of physicians' charges for operations, climbed to 2,595,000, compared with 2,361,000 in 1956. Persons protected by regular medical expense insurance, providing for doctor visits for nonsurgical care, rose to 1,646,000, compared with 1,509,000 a year earlier.

The council is a federation of eight insurance associations representing over 90 per cent of the accident and health insurance business handled by insurance firms.

Dr. E. D. Schwade

NAME DR. SCHWADE TO NEW COMMITTEE

CHICAGO — Dr. Edward D. Schwade, Milwaukee, has been named to the Committee on Neurological Disorders in Industry, a newly-created group which will operate under the A. M. A. Council on Industrial Health.

Dr. Schwade is chairman of the State Medical Society of Wisconsin's Division on Nervous and Mental Diseases.

WISCONSIN FIRM ENGAGED TO PRINT NEW PUBLICATION

CHICAGO—*The AMA News*, to be published by the American Medical Association, will make its bow late this month, and come from the presses of the Perry Printing Co., Waterloo, Wis.

The new newspaper, directed to more than 210,000 physicians, was designed to fill the need for information pertinent to the medical community. It promises to present the news as the doctors want to read it—concise, loaded with facts, giving the medical angles and easy to read.

The AMA News will be a modern, 16-page newspaper, edited to keep the physician well informed in the socio-economic field, concentrating on material not covered in other A. M. A. publications. It will supplement—not replace—other publications of the association.

Regular features will include profiles of prominent men in medicine, a Washington newsletter, editorials, cartoons and humor, letters to the editor, business and investment news, sports, travel, hobbies, law and departments covering nonscientific news of special interest to the medical profession.

In addition to the regular departments, news and pictures of general interest, there will be articles on a variety of subjects of interest to physicians and other professional men in medicine.

The AMA News was conceived a year ago when the A.M.A. House of Delegates requested a publication that would keep physicians informed of news in the socio-economic field. Research conducted this year revealed the need and desire for such a publication.

The *News* will not be a house organ of the association, its editors stated, but will be identified as "The Newspaper of American Medicine." It will carry, however, news of the association's many projects and activities.

(Continued on page 40)

Start New Campaign to Educate Public on Motoring Hazards

MADISON—A statewide campaign to educate the public on the proven value of self-protection measures designed to survive auto crashes was announced recently by the Wisconsin Association of Insurance Agents.

Called in to serve on a consultant basis was a member of the State Medical Society's Division on Safe Transportation, Dr. Dayton H. Hinke of Richland Center.

The association said it would urge motorists to:

1. Demand more safety features in cars they buy.
2. Install safety door locks.
3. Drive with both hands on the wheel.
4. Install seat belts.
5. Keep objects off the back shelf of cars.
6. Check cars to see if certain projections can be eliminated, sharp edges smoothed and hard surfaces padded.
7. Keep control of vehicles when a crash appears inevitable to reduce its seriousness.

Dr. Hinke and Mr. Paul H. Mast, secretary of the association, said that stress would be placed on installation of seat belts.

The State Medical Society is on record urging installation of safety belts in all high school training vehicles. More than a year ago it asked its members to set a good example by installing belts in their own automobiles.

Ask Changes in Migrant Workers' Medical Care

MADISON—Recommendations for revising portions of the State Medical Society's "Guide for Medical Care of Migrant Workers" have come from its Division of Maternal and Child Welfare.

To ascertain the extent of the obstetrical care problem and to secure the cooperation of patients, the division and the State Board of Health Bureau of Maternal and Child Health are attempting to:

1. Secure names of pregnant migrants through crew leaders, volunteer workers and other sources.
2. Establish contact with such known pregnant workers or wives of workers, through county nurses and volunteers, to encourage them to seek pre-natal care. In cases where language is a barrier, to accompany the employee to the physician and assist in having his instructions fully understood.
3. Encourage physicians to use a special report sheet (pre-natal facts) to send to the county nurse in the new location of the pregnant woman, in event she leaves the community and the care of the doctor prior to delivery.

Each year the Wisconsin Maternal Mortality Survey reveals several deaths among migrant workers. Studies indicate that (1) few seek medical care and often present serious problems which might have been controlled by close pre-natal supervision; (2) many present nutritional problems which aggravate conditions having a bearing upon obstetrical care; (3) a language barrier and common use of midwives are associated concerns which often prevent the pregnant migrant from seeking medical care until time of actual delivery.

The Wisconsin State Employment Service reported that there were almost 15,000 migrant workers in the state in 1958.

Also slated for revision in the guide is the category referring to medical and hospital insurance, and another relating to relief of migrants, as outlined by the Division of Public Assistance, State Department of Public Welfare.

The latter is expected to read:

"Migratory workers in need of relief (medical or otherwise) may be granted temporary assistance from the relief-granting unit of government which is responsible for the furnishing of relief in the community where such workers are in need. Such temporary assistance shall not extend beyond 20 days unless a medical emergency requires further extension. . ."

Copies of the guide may be obtained from the State Medical Society, Box 1109, Madison 1.

Rep. Reuss Backs Jenkins–Keogh Bill

WASHINGTON—Rep. Henry S. Reuss (D–Milwaukee) said that the House of Representatives "showed its desire not to penalize millions of Americans who carve their own economic destiny as independent businessmen or professional people" when it approved the Jenkins–Keogh bill recently.

The measure, strongly endorsed by the A. M. A. House of Delegates in June, provides that self-employed persons in the United States might establish their own retirement programs with proper tax deferments similar to those already granted to employed individuals.

Rep. Reuss, listed as a co-sponsor of the Jenkins–Keogh bill, told the house it would allow "our 10 million self-employed persons to provide for their own retirement, from their own funds, without having to pay income tax on the money they set aside until the funds are received later as retirement or survivor benefits." He declared:

"This legislation gives the self-employed person, whether doctor or dentist, the tax deferment advantages in building up his own retirement fund that are now enjoyed by millions of Americans participating in company retirement and pension plans.

"We in the house have declared that we want to preserve individual enterprise, and to encourage self-employed persons to make realistic plans for their retirement, under an equitable tax system. I hope the senate will promptly do the same, and that the president will approve this most important legislation."

Taylor Clinic Takes Over for Hoxsey Clinic

CHICAGO—The A. M. A. Bureau of Investigation reported recently that the former Hoxsey Cancer Clinic at Portage, Pa., is now operating as the Taylor Clinic.

The bureau said the operator of the clinic is an osteopath, Harry R. Taylor, and that he still uses the remedies which were used by Hoxsey during his tenure.

The Pennsylvania Board of Osteopathic Examiners has cited two of the osteopaths at the clinic to show cause why their licenses should not be revoked. The charge was permitting a lay person to benefit from osteopathic practice. The attorney general of Pennsylvania also named an investigation committee, consisting of four doctors of medicine and four osteopaths, to visit the clinic and report their findings.

The Federal Food and Drug Administration said it has been successful in all its actions against the Hoxsey Clinic, including one in which Hoxsey sought to obtain an injunction against the administration, seeking to stop it from posting warning notices in government buildings.

A consent degree of injunction, issued last spring by the federal court in Pittsburgh, forced the Hoxsey branch clinic at Portage to no longer accept patients from outside the state.

In November, 1955, the Texas State Board of Medical Examiners announced the suspension of the licenses of six osteopaths and a doctor of medicine who were alleged to comprise the "staff" of the Hoxsey Cancer Clinic at Dallas. The board charged that they were guilty of "dishonorable and unprofessional conduct which included practicing medicine with an organization fostered and promoted by a layman who has been convicted of the practice of medicine without a license. The charge also struck against certain false and misleading advertising by the clinic.

DOCTOR!

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PRICE COUNTY . . .

Rural Development Program Takes In Medical-Hospital Services

MADISON—The pattern of a county rural development program encompasses many things, and one of the most important is the matter of health and welfare resources.

As a special experimental project, the Price County program was started in February, 1956. Local citizens, motivated by the University of Wisconsin Agricultural Extension Service and other cooperating agencies, organized committees and set to work. They have a Health and Welfare Resources group.

Price County has eight physicians: four in Phillips, three in Park Falls and one in Ogema. Village officials in Prentice, a community of 477, asked the placement service of the State Medical Society to help them find a doctor, to do away with the 13 mile trip to Phillips or 27 miles to Park Falls, when medical attention is needed.

A survey of 23 per cent of the rural households in the county indicated that 78.7 per cent of the residents went to doctors in the county for such medical attention, and 21.3 per cent went elsewhere. Those living in the southern section of the county often go to Medford and Marshfield; those in eastern areas to Tomahawk, with Ashland and Ladysmith also drawing off a limited number from outlying areas.

The only hospital is at Park Falls, and this attracts 67.5 per cent of residents living in the northern half of the county. This declines as distance increases, with others looking for such service outside the county at Ladysmith, Tomahawk, and Medford, particularly.

The hospital facility in Park Falls will be expanded greatly in the next year, to 32 beds. A campaign to raise funds this year went over the top by almost $100,000. Park Falls is located near the north border of the county.

The South Price County Hospital Association, made up of local citizens, meets occasionally to determine the feasibility of setting up a facility at Prentice, Ogema or Phillips. It has not made a recommendation to date.

Approximately 19 per cent of Price residents go outside for dental services, most of them residing in the southern half of the county where such service is available only in Prentice and Ogema.

Some years ago the State Medical Society operated a Price–Taylor county experiment in health insurance. Under this project, borrowers from the Federal Housing Administration were able to obtain most of their medical-surgical care through insurance offered at about $40 per family per year.

In addition to at least one more physician and perhaps another hospital, on which the program's Health and Welfare Resources committee has not taken a formal stand, the area's greatest needs, according to a special study of child welfare services and juvenile problems, are:

A general public understanding of what constitutes child welfare services; more psychiatric and psychological services; an area vocational school; more recreational leadership; opportunity rooms in larger elementary schools, for retarded youngsters; an appraisal of the practice of referring problem children to the court instead of to welfare workers.

The study was conducted by the Division for Children and Youth of the State Department of Public Welfare.

Vern C. Hendrickson, county agent-at-large, said the biggest headaches in developing a successful county program are these:

1. Difficulty in finding human resources, with residents lacking in initiative and push to proceed on planning, organizing and carrying out an enterprise. The load is a burden on a few, he said.

2. People with ability and initiative, with ideas for development, community betterment and progress, etc., lack cash or credit to make headway. Risk capital is much needed.

Prof. Douglas Marshall, of the University of Wisconsin rural sociology department, said residents do much of their own shopping for services and goods as close to home as possible, but will travel up to 60 miles if such services and goods are not available nearby, or not up to their demands.

Announce Essay Contest for Medical Students

CHICAGO—An essay contest for undergraduate medical students has been announced by the American College of Chest Physicians. The articles may be written on any phase of the diagnosis and treatment of chest diseases (cardiovascular or pulmonary).

Cash awards will be made to winners, with the top prize set at $500. Deadline for entries is April 15, 1959.

E. A. Friedberg, of the University of Buffalo School of Medicine, won the 1958 essay contest, writing on "Murmur Production in Aortic Stenosis: An Analysis using a Hydraulic Model."

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MILWAUKEE WISCONSIN

CAMP AMERICAN LEGION ENDS 33rd YEAR OF SERVICE

Upstate Rehabilitation Haven Proves Helpful

LAKE TOMAHAWK—Camp American Legion is a rest and rehabilitation haven for Wisconsin military veterans, the only one of its kind in the country. Established in 1925, the camp is completing its 33rd year of service.

Located on Little Tomahawk and Big Carr lakes, 22 miles north of Rhinelander, the camp was started by the Department of Wisconsin, American Legion, with a state grant, on a lease basis with the State Conservation Commission.

This physical restoration project is provided to all honorably discharged veterans of World Wars I and II and the Korean conflict, regardless of sex, creed or race, without cost. The veterans, who need not be legion members, must come with a certification from their physicians that a period of rest and constructive rehabilitation will assist in recovery of health.

The camp physician is Dr. Gale Huber of Minocqua. He spends one day a week at the camp, and is available for emergency calls at any time. Dr. Huber is assisted by a registered nurse, Mrs. Helen Bowen, wife of the camp superintendent.

Dr. Peter Carnesale, chief of the orthopedic service, Veterans Administration Hospital, Wood, is head of the camp rehabilitation and therapy team.

Disabled veterans, to be eligible to attend the camp, must not be nursing cases or require close medical supervision. They are expected to take care of their own hygienic and personal needs, and be able to move around the camp by wheelchair, or be ambulatory with rehabilitation aids. They are expected to be well oriented mentally, able to understand local rules and have the ability to get along with other campers. Those with active contagious diseases are not permitted.

In 1955 an active corrective therapy rehabilitation program was introduced. Each summer a therapist directs the program, designed as a measure half way between hospital and adjustment to disease and disabilities.

Camp American Legion has been described as an ideal setting for the rehabilitation of convalescing patients. The benefits of outdoor activity, the vacation atmosphere and scenery combine to serve as motivating factors.

DR. PETER CARNESALE, chief of the orthopedic service, Veterans Administration Hospital, Wood, head of the Camp American Legion rehabilitation and therapy team, is shown assisting an above-knee amputee with ambulation training. The combination of the medical attention, sunshine, northland and vacation atmosphere has been credited with unusual success in the rehabilitation of many disabled military veterans.

The camp is well equipped with therapeutic exercise equipment and rehabilitation aids to teach the patients ambulation and self-care activities. Some of the modalities used to improve the various disabilities include:

1) conditioning exercises to develop strength, endurance, coordination, agility and thus prevent physical and psychological deconditioning;

2) functional ambulation and elevation techniques including the use of all types of devices to enable the camper to walk again;

3) self-care activities so the campers may take better care of their immediate needs;

4) therapeutic and recreational swimming adapted for the individual patient's disability;

5) special activities for orientation of blind campers;

6) tests and measurements to check the functional capacities of the more severely disabled patients.

Because complete records are maintained on each camper prescribed for corrective therapy, information is forwarded to referring physicians, upon their request.

Last year 240 patients attended the camp. Their disabilities included:

Cardiacs, hemiplegia, blind, neuromuscular diseases, post-operative surgical, orthopedics, amputees of upper and lower extremities, post-hospital neuropsychiatric cases.

There are fishing trips, hikes, motorboat trips, airplane rides and water skiing shows for the campers. A woodworking shop is located in the main lodge. Cards, movies, television and group singing are popular features of the daily program. Horse-shoe, archery and shuffleboard tournaments are held every week.

Lee Root, rehabilitation program director, said the camping situation demands re-socialization and physical effort on the part of the patients, which they are expected to carry out within the limits of their abilities. He said:

"Medicine has added years to the lives of our disabled; it is our job to add life to those years. We feel that one of the keys to good rehabilitation is motivation. With increased finances, this camp could easily be developed into a hospital-to-job rehabilitation program."

WRIG, WWIS JOIN MARCH OF MEDICINE

MADISON—The recent enrollment of WWIS, Black River Falls, and WRIG, Wausau, has brought the State Medical Society's **"March of Medicine"** network to a high of 52 stations.

During the past three years, the series has grown from 34 stations to its present total, covering all sections of Wisconsin.

Co-sponsored by local medical societies, the **"March of Medicine"** features Dr. Robert C. Parkin, assistant to the dean of the Wisconsin Medical School, and Karl Schmidt, a lay reporter. They discuss pertinent health subjects in an authentic, informal, listenable manner.

SPEAK UP—NOW!

The American Medical Association wants to know what you think about AMA.

What do you like about AMA? What don't you like about AMA? Why? What do you think the AMA should do to be of more help to its members? What policies of AMA do you approve and which do you disapprove, How would you improve the AMA?

A committee composed of three members of the Board of Trustees and three members of the House of Delegates was assigned the task of studying the basic objectives of the association. It is sending questionnaires to many physicians. If you have received such a questionnaire, or even if you have not, would you please take this opportunity to send your comments about AMA to one of the following physicians:

F. J. L. Blasingame, M.D.
General Manager
American Medical Association
535 North Dearborn Street
Chicago 10, Illinois

Lewis A. Alesen, M.D., Chairman
Committee to Study AMA Objectives
124 South LasPalmas Avenue
Los Angeles 4, California

Lawrence College Choice of 14 MDS

MADISON—At least 14 practicing physicians in Wisconsin received all or part of their undergraduate education at Lawrence College in Appleton.

Four are now practicing in Appleton. They are:

Drs. James E. Gmeiner, James W. Laird, F. J. Rankin and Milo E. Swanton.

Other former Lawrence students:

Drs. Reynold O. Bassuener, Milwaukee; Lester J. Bayer, Merrill; Harold F. Borenz, Madison; Harry H. Heiden, Elkhart Lake; Wallace L. Nelson, Wisconsin Rapids; E. Allen Miller, Watertown; Grace E. Pfeifer, Racine;

Charles E. Vedder and James S. Vedder, Marshfield, and Paul E. Wainscott of Menasha.

This information was provided by the dean's office, Lawrence College.

New Privileges Reported at UW

MADISON—Clinical privileges of private practice will be extended to members of the departments of pediatrics and obstetrics-gynecology at the University of Wisconsin Medical School.

This new step in improving relationships with local physicians and providing diversified clinical material for teaching purposes was explained by Dr. John Z. Bowers, dean of the medical school, at a meeting of the State Medical Society's Committee on Coordination of Medical Services.

The new ruling permits Madison area physicians on the staff of the medical school to care for their patients who may be hospitalized at Wisconsin General. Dr. Bowers explained that further expansion of clinical privileges to other specialty groups is contemplated in the future.

Patients admitted under this program will be participants in university teaching program for medical students, interns and residents.

At the same meeting, the committee discussed proposed plans for the University of Wisconsin Medical School to provide medical, surgical and hospital care for university undergraduate students and their dependents. Students would be given the option of participation. A detailed program is to be outlined this fall, although it may not be put into operation for some time.

The committee also discussed plans for consultation practice by University of Wisconsin Medical School faculty members.

Members of the Committee on Coordination of Medical Services are:

Drs. J. F. Wilkinson, Oconomowoc, chairman; Robert S. Gearhart and Eugene J. Nordby, Madison; J. W. Nellen, Green Bay; H. E. Opert, Viroqua; S. E. Gavin, Fond du Lac; L. W. Schrank, Waupun; J. H. Wishart, Eau Claire; Einar Daniels, Milwaukee and M. O. Boudry, Waupaca.

Hospitals Report Admissions Rise

CHICAGO—**Hospitals in this country cared for 22,993,000 patients last year, 900,000 more than in 1956, the American Hospital Association reported recently.**

On any given day in 1957, an average of 1,320,000 patients were hospitalized.

The voluntary hospitals which care for the great majority of the acute short-term cases spent an average of $26.81 a day for the care of each patient, a boost of $1.82 over 1956. Each patient last year spent $198.39; it was $181.43 in 1956. The average patient stay was 7.4 days, compared with 7.5 a year earlier.

Total income from patients, the association said, was $2,878,254,000 in 1957, while expenses aggregated $3,050,398,000.

Average expenditure per day last year for each patient in the nation's federal psychiatric hospitals was $9.73.

The 6,381 non-federal hospitals in this country reported total expense of $5,483,096,000, of which 62 per cent, $3,402,172,000 went for payroll.

In all hospitals last year, an average of 107 personnel per 100 patients was employed. It was 101 in 1956. About 95 per cent of all admissions in 1957 were to general hospitals.

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F.D.A. CONTINUES TO BATTLE QUACK DEVICES

WASHINGTON, D. C. — The Food and Drug Administration continued its relentless fight against adulterated and misbranded drugs and devices in 1957.

The administration's annual report reviewed its major actions, some of which trace back as much as five years.

The report:

After a six-week trial in the Federal court at Pittsburgh a jury in November 1956 sustained the seizure of approximately 500,000 red and black pills destined for national distribution in the treatment of cancer. At the trial the government presented the testimony of about 80 witnesses, mostly physicians and scientists. Included were some of the country's top medical and pharmacological authorities specializing in the field of cancer detection and therapy.

By revealing the complete medical histories of the claimed cancer cures which the appellant presented at the trial and those described in the seized labeling, the government showed that the so-called cures fall in the following categories:

1. The patient never had cancer, or

2. The patient was cured or adequately treated before going to the clinic, or

3. The "cured" patient died of cancer or still has it.

In 1953 the Texas clinic was enjoined from further shipments of the drugs misbranded as an effective treatment for cancer. In denying a motion for a new trial, the court in the Pittsburgh case said that the "medications have again been weighed and found wanting." The Pennsylvania clinic is now under a temporary restraining order to prevent further distribution pending hearing in the fall of 1957 on the government's complaint for a permanent injunction.

In January 1957 a "Public Beware" warning poster was distributed to post offices and other public buildings by the F. D. A. under section 705 (b) of the act, which provides for publicity to be given in matters involving imminent danger to health and gross deception of the consumer. The poster warned that the treatment was worthless for internal cancer and emphasized that cancer can be cured only by surgery or radiation.

PLEASE NOTE!

The chief officer for the Wisconsin–Minnesota F. D. A. district is Maurice P. Kerr, 201 Federal Office building, Washington and Third Avenue South, Minneapolis, Minn. His telephone number is Federal 2–3244 extension 60.

In an editorial at the time the posters went on display, a leading metropolitan paper said, in part:

> *The government has taken its drastic action to protect the American people. The so-called cure is expensive; its price is now to be advertised in every post office. Its price in bitter disappointment can be almost unbearable. And in plain words, the poster says that death may be the price of neglecting proper treatment "because of the lure of a painless cure."*

Previous reports have outlined the injunction and contempt litigation based on persistent attempts to traffic in "orgone" devices for the cure of cancer and other serious conditions, and the fine and jail sentences imposed in May 1956. After the Supreme Court declined a review in February 1957, the district court refused arguments to set aside or reduce the penalties of two years in jail for the promoter and one for his distributor.

Another treatment for cancer, and nostrum for diseases in general, under the guise of a blood and kidney remedy, brought a conspiracy trial, injunction of the individuals and firms manufacturing and distributing the drug, prosecution of the manufacturer for criminal contempt of the injunction, and jail sentences suspended on condition that they not manufacture, possess or sell any remedy for the treatment of animal or human disease.

Other drug injunctions granted during the year were against a naturopath who distributed from his clinic herbs with excessive therapeutic claims; a manufacture

(Continued on page 40)

B.B.B. SERVICES SET NEW HIGH

MILWAUKEE—More consumers than ever—almost 2,500,000 of them —turned to America's 111 Better Business Bureaus for help in 1957, according to the Better Business Bureau of Milwaukee.

The total of 2,404,809 inquiries represented a seven per cent gain over 1956 and a 140 per cent climb over 1949.

For every consumer registering a complaint about a business practice already consummated, there were seven who called on their B.B.B. office for advance information first.

"The fact more consumers are checking propositions first and avoiding cause for complaint emphasizes the positive aspect of the American Better Business Bureau movement," the Milwaukee office stated.

"As fact-finding agencies, the bureaus are best prepared to supply consumers with detailed advance information about propositions and help them avoid throwing their money away."

Top area of activity was the home improvement and maintenance industry, accounting for 177,-844 inquiries and 31,139 complaints. Fifty-three per cent of all activity last year was in the merchandise field. Twenty-one per cent was commercial and 16 per cent financial.

During the past year, bureau representatives examined and checked carefully on many thousands of advertisements in newspapers and magazines, on TV and radio, and elsewhere. Of these, 26,-096 were considered suspect for lack of truth or presence of misrepresentation. Because of increasing cooperation, however, on the part of media executives and advertisers, only 493—two per cent—had to be referred to legal authorities for action. Many others were corrected voluntarily in the public interest and in the interest of the industry being served, the Milwaukee office said.

There were 20,314 inquiries and 5,527 complaints relating to drugs; 18,808 and 3,486 to food, and 47,-786 inquiries and 6,269 complaints relating to professional services.

GOVERNMENT S–S HANDOUTS HIT

WASHINGTON, D. C.—The National Conference of Catholic Charities made it clear recently it wants no help from government in the field of hospital and medical group insurance.

Msgr. John O'Grady, conference secretary, said that over-all federal relief programs "represent the welfare state in its most complete form."

He testified before a house committee which is considering changes in the Social Security Act, and said:

"At this time, we are not sympathetic about having the government enter the field of hospital and medical group insurance. We believe that it brings the federal government too close to the problems of family life. It is an entire departure from the objectives of a social insurance program."

Msgr. O'Grady added that studies of the aging made by the conference "do not justify our supporting a program for the entrance of government into this field."

STATE DEATHS TOTAL 37,185

MADISON—Heart disease again led causes of death in Wisconsin in 1957, claiming 15,006 lives, the State Board of Health reported recently.

Deaths totalled 37,185, at an average age of 64.4 years.

Cancer took 6,323 lives; cerebral vascular lesions 4,676; accidents 1,955; diseases of the arteries 1,088; pneumonia 1,047; diabetes 767; congenital malformations 517; birth injuries 468; suicide 415 and cirrhosis of the liver, 350.

Slight increases in death causes came in heart disease and pneumonia.

There was a four per cent drop in accident fatalities, claiming 81 fewer lives than in 1956. This included a reduction of 31 motor vehicle deaths over the previous 12-month period.

Births totalled 96,398, marking the fourth straight year in which they exceeded the 90,000 level.

The total state population last year was 3,805,050, a 1.2 per cent rise over 1956. Since 1950, urban population has climbed 13.5 per cent to 2,163,864 persons, while rural population gained 7.4 per cent, to 1,641,186.

SEE $6,300,000 IN FEDERAL AID FOR WISCONSIN HOSPITALS

MADISON—More than $6,300,000 in federal aid is expected to be available for construction of hospital facilities during the fiscal year starting July 1, the State Board of Health reported recently.

Vincent F. Otis, director of the board's Division of Hospital and Related Services, asked hospitals and related institutions to review their needs and determine their eligibility.

The federal hospital aid program has House of Representatives approval, and senate action is pending. The federal program calls for supplying 60 per cent of the cost of improvement projects, with local communities providing the remainder.

Otis listed communities which currently have priority in applying for available funds.

Communities listed as having such priorities were:

General Hospital Beds—Crandon, Eagle River, Medford, Sturgeon Bay, Black River Falls and Baraboo–Prairie du Sac.

Chronic Disease Hospital Beds—Appleton, Janesville, Marshfield, Neenah, Oshkosh and Wausau.

Nursing Home Beds—Arcadia, Boscobel, Berlin, Spooner, Oconto Falls, Grantsburg, Medford, Algoma, Friendship, Ladysmith, Woodruff, St. Croix Falls, Mauston, Menomonie, Sturgeon Bay, Marinette, Marshfield, Chilton, Baraboo, Waupun, Ripon, Hartford, West Bend, Two Rivers, Beloit and Neenah.

Proposed Rehabilitation Facilities—Eau Claire, Green Bay, La Crosse, Madison, Milwaukee, Oshkosh, Racine and Wausau.

Proposed Public Health Units—Appleton, Ashland, Beaver Dam, Chippewa Falls, Clintonville, Dodgeville, Eau Claire, Fond du Lac, Fort Atkinson, Green Bay, Janesville, Kenosha, La Crosse, Lancaster, Madison, Manitowoc, Marinette, Mauston, Menomonie, Merrill, Milwaukee, Oshkosh, Portage, Racine, Rhinelander, Rice Lake, Richland Center, Sheboygan, Sparta, Stevens Point, Sturgeon Bay, Superior, Waukesha, Wausau, West Bend and Whitehall.

Nervous and Mental Hospital Beds—Beloit, Fond du Lac, Janesville, Kenosha, Marshfield, Oshkosh, Wausau, Neenah and Manitowoc.

ON THE S.M.S. CALENDAR

SEPTEMBER

27–28—S.M.S. House of Delegates, Stevens Point

OCTOBER

1—Claims Committee, S.M.S.

1—Postgraduate Circuit Teaching Program, Eau Claire

2—Postgraduate Circuit Teaching Program, Wausau

8—Postgraduate Circuit Teaching Program, Janesville

9—Postgraduate Circuit Teaching Program, Neenah

10–11—College Health Conference, Milwaukee

10–11—University of Wisconsin Postgraduate Course on Advances in Anesthesia and Resuscitation, Madison

16—Symposium on Vitamin B and Bone Metabolism, Madison

16—Postgraduate Circuit Teaching Program, Sheboygan

16–18—State Board of Medical Examiners, Madison

22—Postgraduate Circuit Teaching Program, Marinette

23—Postgraduate Circuit Teaching Program, Rhinelander

24—Postgraduate Circuit Teaching Program, Superior

30—Postgraduate Circuit Teaching Program, Madison

NOVEMBER

7—Conference on Athletic Injuries, Milwaukee

20—Postgraduate Circuit Teaching Program, Stevens Point

A.M.A. NEWS . . .

(Continued from page 33)

Dr. Edwin S. Hamilton, Kankakee, Ill., chairman of the A. M. A. Board of Trustees, said the News would be distinctly different from any other publication, would be lively, terse, interesting, timely and practical.

"Its purpose will be to enlighten, and to be an actively helpful force in the lives of its readers—the physicians of America," Dr. Hamilton said.

The *News* will be published every other week, and be sent to all A. M. A. members.

The Perry Printing Co. is highly regarded in its field, and has been rated as exceptionally qualified and suitable for a printing load of this stature.

F.D.A. . . .

(Continued from page 38)

restrained from false and misleading claims for an ulcer "remedy"; a distributor of homeopathic remedies seriously misrepresented by collateral literature; and a distributor of "vim and vigor" proprietary remedies with promotion especially designed for the aging.

Ten seizures were made of a vine and root imported without a new-drug application and promoted with claims that it was an effective aphrodisiac. Agents used reprints of a sensational magazine article entitled "The Vine that Makes You Virile." Licensed drug channels did not handle the product.

The total of 122 seizure actions against drugs (excluding vitamin preparations) was fairly evenly divided between inherent defects and misbranding.

Ten other shipments were seized because they had no effective new-drug applications. About half of them consist of untried products that may be dangerous and/or promoted with unfounded claims. The others were purchased by small distributors from recognized manufacturers and repackaged under their own names without filing new-drug applications.

Included in misbranded devices seized were a number of low-grade uranium items bearing claims for arthritis and other ills. Other devices seized were stretching harnesses, electronic condensators, oscillators and massagers.

A.M.A. Council Outlines Ethics Status of Diagnostic Clinics

CHICAGO—As a supplement to the Principles of Medical Ethics, adopted by the A. M. A. House of Delegates last June, the association's Judicial Council this spring issued a series of "opinions and reports."

The series was prepared to assist county and state medical societies in the interpretation of the new revised principles, as follows:

"DIAGNOSTIC CLINIC"

The name "clinic" because of its association with the earlier uses of the term, implies a very superior service by very superior individuals. This is frequently not the case. If the A. M. A. is to define a diagnostic clinic it must be done in a way that will represent the efficiency that modern scientific progress has made possible to the doctor of medicine who has kept abreast of that progress, and the idealism or ethical principles that for hundreds of years have been our most cherished heritage as a profession. The Judicial Council submits the following as its opinion:

(1) A diagnostic clinic is an organization of physicians whose sole work in the clinic is to make or supervise diagnostic examinations of patients referred to the clinic by doctors of medicine, or to collaborate in general diagnostic surveys.

(2) The reports of the diagnostic clinic on examinations and tests are made only to the referring physician unless he requests that the case and the recommendations for treatment be discussed with the patient as a part of a professional consultation at which the relationship of the results of the diagnostic studies to the general condition of the patient is open for discussion. In such case, discussion is only by a member of the staff.

(3) The staff of the diagnostic clinic should include representatives from all the specialties that are of recognized diagnostic usefulness. Every clinical examination, laboratory test or x-ray procedure is made by a physician who specializes in that field or under his supervision. They exercise fully their abilities.

(4) The control of the clinic must be vested in one or more members of the professional staff. Any profits are to be apportioned only to the members of the staff actually engaged in the work of the clinic. There must be no dividends, bonuses or salaries paid any individual except for services rendered.

(5) The clinic must be governed in its activities by the same ethical principles as apply to any individual member of the A. M. A.

It is recognized that under this definition only in cities large enough to support the various specialists needed can a diagnostic clinic be established or maintained. Unless the specialists are available, it is not a diagnostic clinic worthy of the name.

While the Judicial Council does not "define" a clinic, it presents for the consideration of the profession a definition of a "diagnostic clinic", and gives the high standards associated with "clinic" service in the minds of the general public. The Council seems to intimate that it is a responsibility of the profession to be sure that the specialty services synonymous with the use of the word "clinic" be provided, if any group of physicians make use of the term.

A.M.E.F. REPORTS CONTRIBUTIONS

CHICAGO — Contributions were received by the American Medical Education Foundation from the following Wisconsin sources last month:

Jefferson County Medical Society; Grant County Medical Society Auxiliary; Drs. John D. Conway, Thomas W. Kirmse and Anne E. Roethke, Milwaukee; and Mrs. Dexter H. Witte, Milwaukee; Mrs. F. J. Rankin, Mrs. W. S. Giffin and Mrs. Ralph O. Kennedy, Appleton, and Mrs. M. L. Kuhs, Green Bay, auxiliary members.

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- in pregnancy when vomiting is persistent
- following neurosurgical diagnostic procedures
- in infections, intra-abdominal disease, and carcinomatosis
- after nitrogen mustard therapy

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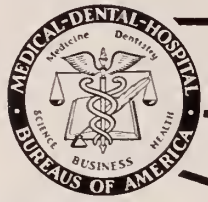

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204 First National Bank Building
MENOMONIE, WISCONSIN

MEDICAL–DENTAL SERVICE BUREAU
A division of Commercial Service Bureau
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why combine the two? *For greater therapeutic success:* In clinical trials, CARTRAX was demonstrably superior to previous therapy, including PETN alone. Specifically, 87% of angina patients did better. They were shown to suffer fewer attacks . . . require less nitroglycerin . . . have increased tolerance to physical effort . . . and be freed of cardiac fixation.

1. Russek, H. I.: Postgrad. Med. *19*:562 (June) 1956.

Dosage and Supplied: Begin with 1 to 2 yellow CARTRAX "10" tablets (10 mg. PETN plus 10 mg. ATARAX) 3 to 4 times daily. When indicated this may be increased by switching to pink CARTRAX "20" tablets (20 mg. PETN plus 10 mg. ATARAX.) For convenience, write "CARTRAX 10" or "CARTRAX 20." In bottles of 100.

CARTRAX should be taken 30 to 60 minutes *before* meals, on a continuous dosage schedule. Use PETN preparations with caution in glaucoma.

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News Items and Personals*

Doctor McCarey Honored

A past president of the State Medical Society, *Dr. Arthur J. McCarey* of Green Bay, was honored recently with a medallion for his service to the Society and a gold pin for being a founder of the Wisconsin Surgical Society.

Doctor Marshall Guest Lecturer

On June 25, *Dr. Wallace Marshall,* delivered a lecture before the 114th Annual Convention of the American Institute of Homeopathy held in New York City. The subject of his speech was "Course of Inflammatory Edema and Its Modern Therapy."

Doctor Marshall is a member of the Manitowoc Chapter of the American Academy of General Practice and resides in Watertown.

Heads Psychiatric Unit

Dr. Harold Schroeder, Racine, was named president of the Association of Wisconsin Psychiatric Clinics for Children at its annual meeting held at Milwaukee in June. Doctor Schroeder is engaged in practice at the Racine Community Guidance Center.

* Physicians whose names are printed in italics are members of the Society.

New Doctor at Boyd

A native of British Columbia, Dr. D. A. Sallis, moved to Boyd to begin practice in July. Doctor Sallis graduated from the Queen's University at Kingston, Ontario, in 1955 and interned at St. Joseph's Hospital in Flint, Michigan, the following year. For the past two years he has been practicing in Smithville, Ontario.

Doctor Smollen at Racine

Dr. William J. Smollen, who has been a fellow in surgery in the Mayo Foundation in Rochester, Minnesota, has left that city and will be located in Racine, Wisconsin.

Marshfield Clinic Has Two New Specialists

On July 1 two physicians joined the staff of the Marshfield Clinic bringing the total number of physicians affiliated with the clinic to 34. The newest members are *Dr. Dean A. Emanuel,* an internist just released from active duty in the U.S. Army, and *Dr. John W. Rupel,* who completed a residency in obstetrics and gynecology at St. Mary's and Mount Sinai Hospitals in Milwaukee prior to locating in Marshfield.

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MEDICAL STAFF

William L. Herner, M. D., Medical Director

John F. Wyman, M. D.
Hubert H. Blanchard, M. D.
John E. Leach, M. D.
Lloyd F. Jenk, M. D.
Richard O. Barnes, M. D.
John R. Whitty, M. D.

Preston W. Thomas, M. D.

Facts about

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WISCONSIN PHYSICIANS SERVICE

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OUTLINE OF THE NEW WISCONSIN PHYSICIANS SERVICE HOSPITAL PLAN

On June 4, 1958, the Council of the State Medical Society authorized the sale of hospital coverage described below to complement the Wisconsin Physicians Service "A", "B", and "Special Service" surgical-medical coverages. This new hospital plan is sold at rates competitive with other insurance plans.

ROOM AND BOARD—

Because hospital charges vary in different areas of the state, Wisconsin Physicians Service offers a choice of rates from $8 to $18 per day. The purchaser selects the rate most common to his area. The rate selected is payable for private, semi-private, or ward rooms.

DURATION OF BENEFITS—

Room and board and miscellaneous expenses are available up to a maximum of 120 days per confinement.

CHOICE OF HOSPITAL—

The Wisconsin Physicians Service hospital benefits are payable for services provided in hospitals anywhere.

MISCELLANEOUS HOSPITAL EXPENSES—

Full payment is made for all hospital charges for miscellaneous services as a bed patient including x-ray services and all drugs and medications.

Full payment is also made for all hospital outpatient charges for the initial visit in case of surgery, or within 48 hours in case of injury or accident.

MENTAL AND NERVOUS DISORDERS—

Room and board charges will be paid up to the room and board rate selected and for as long as 70 days. No miscellaneous hospital expenses are payable for these conditions.

MATERNITY—

Payment will be made for hospital charges for mother and child up to a maximum of 10 times the room and board rate selected. The purchaser has the option of choosing a maternity benefit which pays room, board, and miscellaneous expenses for up to 10 days.

EXCLUSION—

Expenses incurred primarily for diagnostic purposes; expense as a result of pregnancy or for childbirth unless covered by a family contract; services covered by Workmen's Compensation or similar legislation, or furnished by the Veterans' Administration, or provided under the laws of the United States or any state or political subdivision where the participant is not liable for the cost; expense incurred by a participant in a sanitarium (except as provided above) or incurred in any institution which is primarily a place for rest, for the aged, for treatment of drug addiction or alcoholism or a nursing or convalescent home.

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Write: P. O. Box 1109, MADISON, WIS.

Phone: ALpine 6–3101, MADISON, WIS.

Opens La Crosse Office

A 1950 graduate of the University of Wisconsin Medical School, Dr. Albert L. Fisher has opened an office in La Crosse for the practice of psychiatry. Formerly staff psychiatrist at the Veterans Administration Hospital at Tomah, Doctor Fisher received his specialty training at Hastings State Hospital, Nebraska, at the Veterans Administration Hospital in Minneapolis, Minnesota, and at the University of Minnesota Medical School. He is a diplomate of the American Board of Psychiatry and Neurology.

Dr. Kalina Named County Psychiatrist

The Brown County Welfare Department announced recently that Dr. Bernard Kalina would assume the duties of psychiatrist attached to the Brown County Child Guidance Clinic in September when his clinic studies are completed at the University of Omaha. He will also be associated in practice with *Dr. Charles Wunsch* of Green Bay.

Doctor Kalina graduated from Long Island University and took genetics at the University of Iowa before receiving his medical degree from that school in 1954. His internship was served at Meadow Brook Hospital, Hempstead, New York.

Kiel Honors Doctor

Residents of the Kiel community in June paid tribute to *Dr. Daniel F. Nauth*, one of its longtime citizens. A native of the area, he attended school at Plymouth and taught school nearby before entering the medical profession.

Doctor Nauth has practiced in Kiel since 1907 and has been president of the Citizens State Bank since its organization in 1914.

Following the dinner given in his honor, Doctor Nauth was presented with a special citation in recognition of his 51 years of medical practice. The citation was presented to him by *Dr. J. A. Russell*, president of the Sheboygan County Medical Association, in behalf of the State Medical Society.

Senator Alfred A. Laun served as master of ceremonies and *Dr. Robert J. Samp*, Madison, was the principal speaker on the program.

New Doctor Joins Hospital Staff

Dr. K. O. Cejpek, a 1954 graduate of the University of Zurich in Switzerland, recently joined the department of pediatrics at Grandview Hospital, La Crosse. Doctor Cejpek completed his medical training by interning at the Good Samaritan Hospital, Cincinnati, Ohio, and studying pediatrics in Zurich, Switzerland, Cleveland, Ohio, and Milwaukee.

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15 mg. (1/4 grain)—prolongs action

For continuing prophylaxis patient swallows the entire Dilcoron tablet.
Average prophylactic dose:
1 tablet four times daily.
Therapeutic dose:
1 tablet held under the tongue until citrus flavor disappears, then swallowed.

Bottles of 100.

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Doctor Marshall Honored

July 20 was "Doctor Marshall Day" when businessmen and the Hollandale Community Club joined forces to pay tribute to their veteran doctor, *Dr. S. B. Marshall.* The day started with a parade with prizes awarded for the three best floats. After the parade there was a program in the community to honor the doctor.

Persons who were born with Doctor Marshall in attendance were invited to attend the occasion. He has averaged about 60 baby cases a year since locating in Hollandale 25 years ago.

Returns to Lancaster

Having recently completed a year of surgery residency in Eau Claire, *Dr. Robert Jackson* resumed his practice in Lancaster during July. Doctor Jackson is affiliated with *Dr. Warren Fieber.* Their present offices are in the process of being remodeled.

Doctor Majeski Moves

With the near completion of a new clinic and office building, known as the Luxemburg Clinic, *Dr. H. E. Majeski* became the first occupant in June. He has been located in Luxemburg since beginning practice in 1951.

Band Scholarships Given by Neenah Doctor

Four junior high students attended a one-week band clinic at the University of Wisconsin through a scholarship fund set up by *Dr. T. D. Smith.* The band director, Mr. Les Mais, selected the students who received the merit awards.

Doctor Smith, who retired from his Neenah practice earlier this summer, said, "The enhanced appreciation of music that the boys (his sons) acquired while attending the Neenah schools is why we want to offer these scholarships to four of Les Mais's students."

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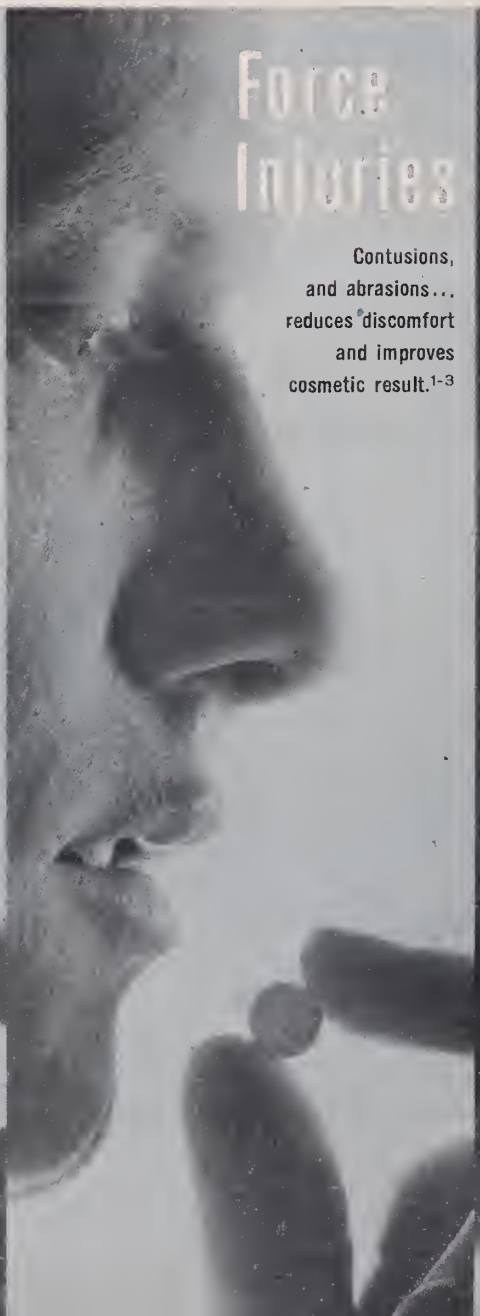
Controls Inflammation and Swelling...Relieves Pain... Promotes Healing Through Enchancement of Fibrinolysis at the Site of Trauma or Infection.

References: 1. Innerfield, I.; Shub, H., and Boyd, L. J.: New England J. Med. 258: 1069 (May 24) 1958. 2. Miller, J. M.; Godfrey, G. C.; Ginsberg, M. J., and Papastrat, C. J.: J. A. M. A. 166:478 (Feb. 1) 1958. 3. Davidson, E.; Prigot, A., and Maynard, A. de L.: Harlem Hosp. Bull. II: 1 (June) 1958 *Reg. U. S. Pat. Off.



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Administration: VARIDASE Buccal Tablets should be retained in the buccal pouch until dissolved. For maximum absorption patient should delay swallowing saliva.

Dosage: One tablet four times daily for a minimum of three days. When infection is present, VARIDASE Buccal Tablets should be given in conjunction with an antibiotic such as ACHROMYCIN* V Tetracycline and Citric Acid.

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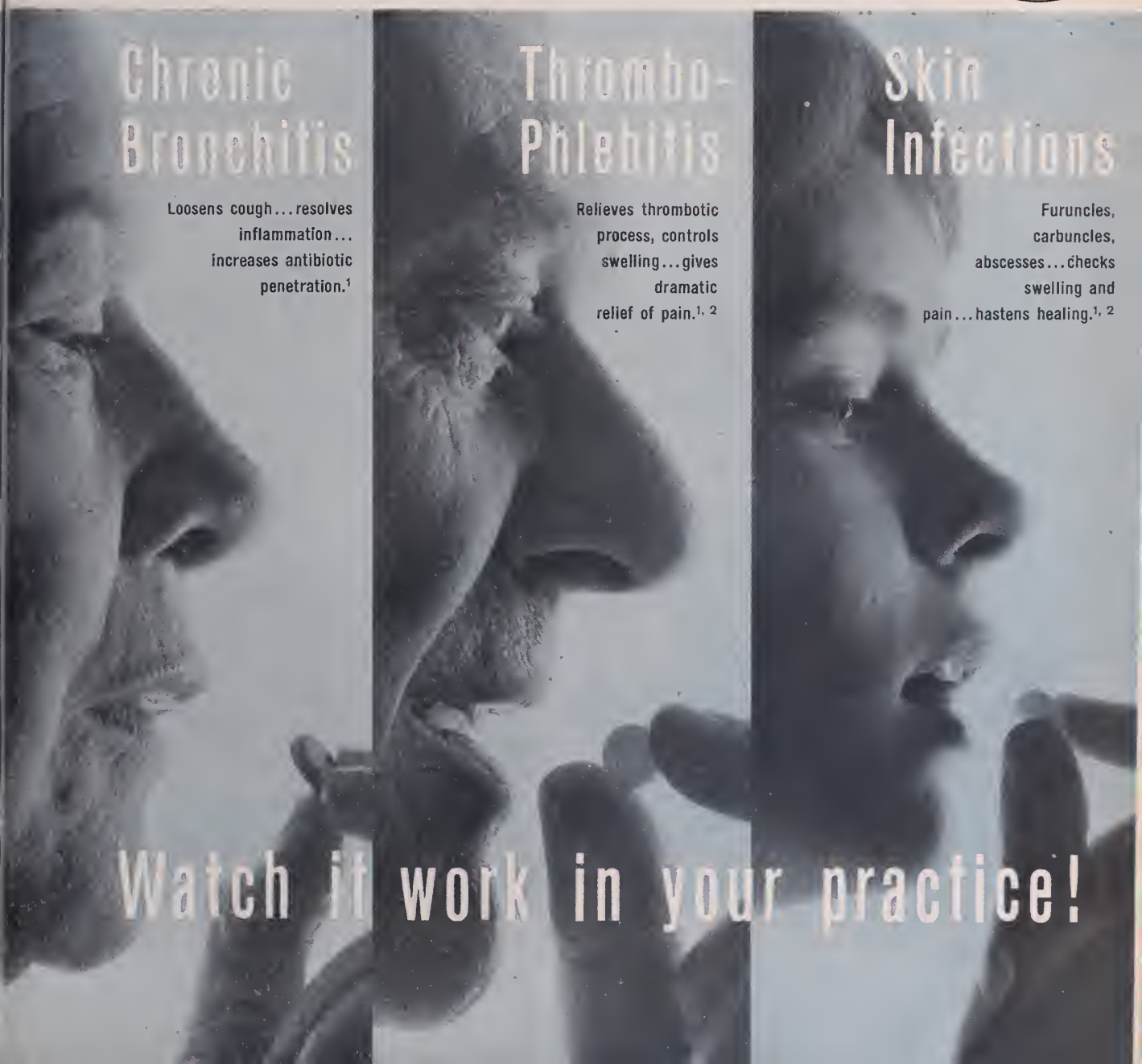


THIRD AND TWELFTH DISTRICTS NEWS

Postgraduate Training

Dr. B. F. Stengel returned recently from serving two years as a captain in the U.S. Air Force and as flight surgeon at Reese Air Force Hospital at Lubbock, Texas, to resume his medical education in the field of general surgery at Wood. A 1955 graduate of Marquette University School of Medicine, Doctor Stengel interned at St. Francis General Hospital, Peoria, Illinois. His home is in Suring.

Joins Gastroenterological Group

It was announced recently that *Dr. M. C. F. Lindert* was elected to active membership in the American Gastroenterological Association. Doctor Lindert is a specialist in internal medicine, practicing in Milwaukee.

Affiliates with Madison Clinic

An internist, *Dr. William Rock*, has joined the East Madison Clinic. Doctor Rock graduated from Loyola University Medical School in 1953, interned at Los Angeles County General Hospital and served a residency in Mercy Hospital and Westside Veterans Hospital in Chicago. Before entering practice he held a fellowship at the Madison Veterans Administration Hospital for further studies in pulmonary diseases.

Receives Specialty College Post

The American College of Chest Physicians recently named *Dr. Mischa J. Lustok*, Governor of the College for the State of Wisconsin. A specialist in cardiovascular diseases, he was certified by the American Board of Internal Medicine in 1946. Doctor Lustock has been in practice in Milwaukee since 1939 and devotes a portion of his time to Marquette University School of Medicine, teaching undergraduate and postgraduate classes.

Doctor Curreri Attends Conference Abroad

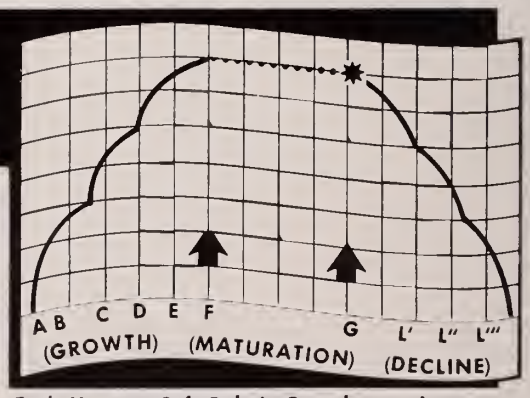
Dr. A. R. Curreri of the University of Wisconsin's Cancer Research Hospital presented a paper on "Further Clinical Studies with 5–Flurouracil" at the Seventh International Cancer Congress. He left July 4 to attend the meetings being held in London, England.

Doctor Parkin on Committee

Dr. R. C. Parkin, Assistant to the Dean of the University of Wisconsin Medical School, has been asked to serve on the planning committee and to participate in the Conference on Medical Education for Foreign Scholars which will be held on the University of Iowa Medical School campus next year. For the past two years the sessions have been at the University of Wisconsin.

...to postpone the "G" point*...

℞ Geritag



For patients over 40, The G POINT (point of declination in life) can be postponed!

Properly balanced Androgen — Estrogen — nutritional therapy may prevent premature aging and damage of gonadal decline and nutritional inadequacy.

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Ethinyl Estradiol	0.01 mg.	Riboflavin	2 mg.
Ferrous Sulfate	50 mg.	Pyridoxine Hcl.	0.3 mg.
Rutin	10 mg.	Niacinamide	20 mg.
Ascorbic Acid	30 mg.	Manganese	1 mg.
B-12	1 mcg.	Magnesium	5 mg.
Molybdenum	0.5 mg.	Iodine	0.15 mg.
Cobalt	0.1 mg.	Potassium	2 mg.
Copper	0.2 mg.	Zinc	1 mg.
Vitamin A	5,000 I.U.	Choline Bitartrate	40 mg.
Vitamin D	400 I.U.	Methionine	20 mg.
Vitamin E	1 I.U.	Inositol	20 mg.
Cal. Pantothenate	3 mg.		

Also available as injectable.

*Chappel, C.C., J.A.M.A., 162: 1414, (Dec. 8) 1956

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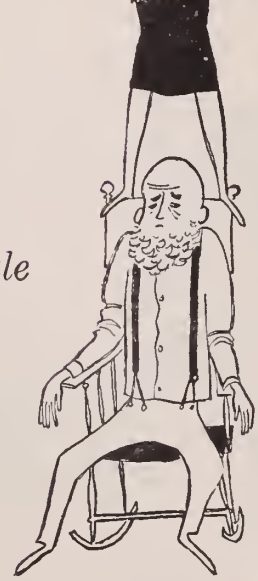

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hormonal, hematinic and nutritional support

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when more than a hematinic is indicated

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. . . and he solved their problems with a nutrition product from ROERIG

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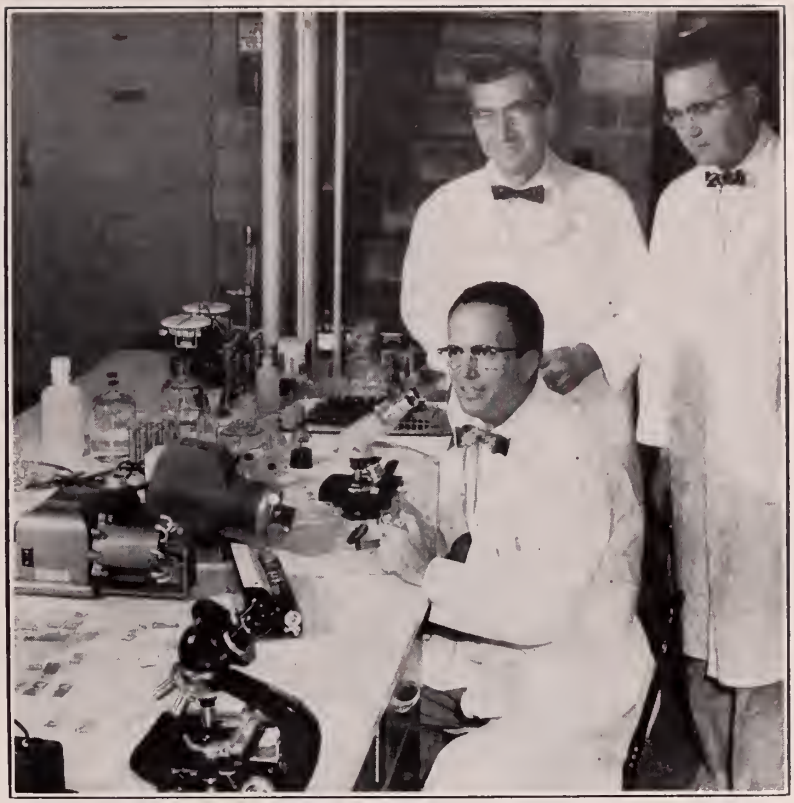
Science for the World's Well-Being

New Research Center at U. of W.

With the appointment of new faculty members and the opening of the hematology research laboratories in the Children's Hospital unit of the University Hospitals, a research unit devoted to studies of blood diseases in children has been established at the University of Wisconsin in the Department of Pediatrics.

The research activities are being directed by three pediatricians who are actively engaged in research in various blood diseases in children. They are Dr. Nathan J. Smith, professor of pediatrics, Dr. Harry A. Waisman, professor of pediatrics, and Dr. C. W. Reiquam, instructor in pediatrics at the University. Currently they are being assisted in their research work by Mr. Paul Trump, Mr. William Yount, Mr. James Urban and Mrs. Gerda Merrens.



Shown above are three pediatricians from the Department of Pediatrics, University of Wisconsin, as they look over the new Hematology Research Laboratory in the basement of the Children's Orthopedic Hospital. Seated at the microscope is Dr. C. W. Reiquam, standing behind him is Dr. Harry A. Waisman, and at the right is Dr. Nathan J. Smith.

This new research unit complements the research activity that has been going on in this area in the University under the direction of Doctor Waisman. New laboratory space has been opened to make possible investigations of a more extensive nature than previously undertaken in the Sarah Workman Research Laboratories in the Department of Pediatrics.

Current investigations being conducted in the new pediatric hematology research laboratory deal with amino acid metabolism in leukemic subjects. These studies are designed to identify functioning differences between white blood cells of leukemic patients as compared to those in the normal. Investigations regarding the role of vitamin B_6 in the formation of hemoglobin are in progress. Additional nutritional studies concerned with the effect of iron and certain proteins on blood production has also been undertaken in the laboratory. This work is being done collaboratively with faculty members from the University of Panama.

Writes Guest Editorial

Dr. Harry Beckman, director of the department of pharmacology of Marquette University School of Medicine, Milwaukee, was author of the guest editorial in the July 26 issue of the Journal of the American Medical Association. He wrote on "Expectorants."

Dean Bowers A Speaker

Dr. John Z. Bowers, Dean of University of Wisconsin Medical School, and Editor-in-Chief of the Journal of Medical Education, will be a speaker at the 15th annual meeting of the American Medical Writers' Association to be held September 26 in Chicago. His topic is, "Cross Section of the Medical Editor's Mind".

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BECKER, M. C., Simon, F. and Bernstein, A.: J. Newark Beth Israel Hosp. **9**:58 (January) 1958.

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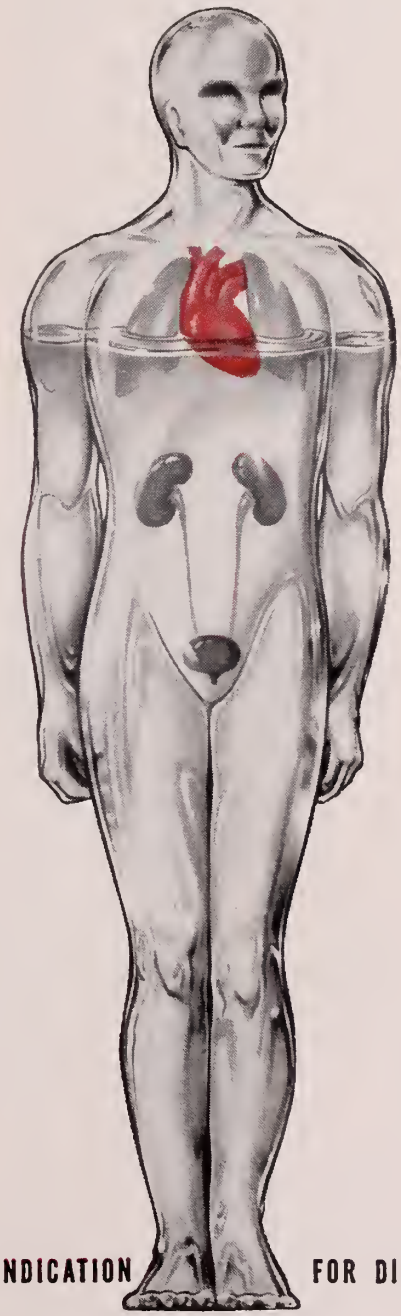
failure

markedly relieves pulmonary edema



ANY INDICATION FOR DIURESIS IS AN INDICATION FOR DIURIL

U. of W. Faculty Appointments

The University of Wisconsin Medical School recently announced seven faculty appointments, one at the rank of associate professor and six as assistant professor.

Dr. Arthur A. Siebens, former associate professor at the State University of New York and a recognized authority in the field of pulmonary function, was named director of the Respirator Center, associate professor of medicine, and associate professor of pediatrics.

Robert L. Metzenberg, Jr., and *Dr. Carl H. Fellner,* staff members during 1957–58, received appointments as assistant professor. Dr. C. W. Reiquam, also a staff member, is an instructor.

Third appointment in the department of pediatrics was Dr. Charles Lobeck as assistant professor.

John R. Cameron, an alumnus who holds the M.S. and Ph.D. degrees from Wisconsin, has returned as assistant professor of radiology.

A new assistant professor of psychiatry is Dr. Seymour Halleck, who holds the University of Chicago B.S., Ph.D., and M.D. degrees.

Wins Golf Honors

Dr. S. M. Feld, shot 73 to win the 31st annual golf tournament of The Medical Society of Milwaukee County on July 22 at the Ozaukee Country Club. *Dr. S. E. Zawodny,* followed with a 75. Over 100 golfers participated in the tournament.

New Head of Dermatology Department

Dr. David W. Kersting has been appointed Professor and Chairman of the Department of Dermatology at Marquette University School of Medicine, succeeding *Dr. Harry R. Foerster* who becomes a Clinical Professor Emeritus. The announcement was made August 15 by Fr. Edward J. Drummond, S.J., Academic Vice-President of the University, and *Dr. John S. Hirschboeck,* Dean of the medical school.

Dr. Kersting is the director of graduate training in dermatology at the Veterans Administration Hospital at Wood and at Marquette, and he is Chief of the Dermatology and Syphilology Section at Wood. He will direct undergraduate teaching and research at the medical school.

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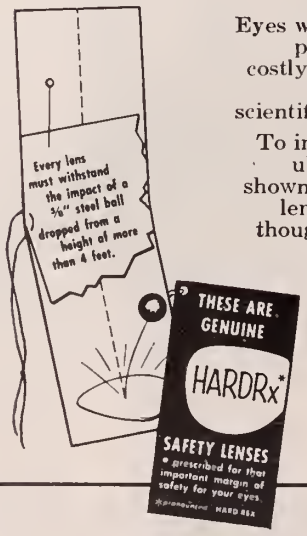

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Staff Changes at Milwaukee County Hospital

Dr. William W. Engstrom has been appointed Director of Medicine following the retirement of *Dr. Francis Murphy.* Doctor Engstrom is a University of Minnesota Medical School graduate (1940) with further training at Johns Hopkins, New York University, and the Mayo Foundation, followed by two and one-half years of military service in the United States Army. From 1946 to 1950 he was on the faculty of Yale University School of Medicine, leaving there as an assistant professor of medicine to accept appointment as associate professor of medicine at Marquette University School of Medicine. He has developed the Metabolic Laboratory and service in the Milwaukee County Hospital and since January of 1958, has acted as assistant director of medicine.

Dr. Robert Ewer is the new assistant director of medicine. He is a graduate of Northwestern University. He interned at Cook County Hospital and had a residency in internal medicine at the Milwaukee County Hospital, following which he had a year in the medical department of Johns Hopkins Medical School.

Dr. William Wilcox joins the hospital staff as radiologist. He also, is a Northwestern University graduate, with internship at St. Luke's Hospital in Chicago. Doctor Wilcox has served twice in the military forces. He had his radiology training at the University of Minnesota and the Veterans Administration Hospital, from which position he comes to the Milwaukee County Hospital. Doctor Wilcox's home was Stanley, Wisconsin, and he had the first two years of his medical training at the University of Wisconsin.

Dr. Rocco Latorraca fills the new position of pathologist and thus completes the staff of the Department of Medical Laboratories of the Milwaukee County Hospital. Doctor Latorraca has his medical degree from the State University of New York College of Medicine at Brooklyn and he had his pathology training at Tufts University and the New England Medical Center in Boston.

Dr. David W. Barrow has resigned his position as assistant director of surgery to go into private practice in California.

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Doctor Prouty to Peru

When *Dr. Margaret Prouty,* pediatrician, on the Jackson Clinic staff, Madison, left June 20 for Peru, she took along an unusual pair of gloves. The gloves will be used for climbing some 23,000-foot peaks in the Cordillera Blanc with a Sierra club group.

The gloves are unusual for several reasons. First, they're called "double compartment" mittens because they're made with two compartments with down between, for warmth. Second, they cost $18 a pair. And, third, there is a strip of synthetic ermine (made of rayon) about two inches wide sewed across the back of each pair.

"When you're climbing mountains in cold weather so that your breath turns to steam and condenses on your face, you often have to sniffle," Doctor Prouty says. "But it would be extremely difficult and time-consuming to take off your gloves, unbutton your several jackets, and find a handkerchief so often, so we just use the back of our mittens."

"The mittens are rough, however, and even a few rubs makes your nose sore—so we sew strips of fur across the backs and it turns them into perfect 'sniffers' ".

New Doctors at Jackson Clinic

An obstetrician and gynecologist has joined the staffs of Methodist Hospital and Jackson Clinic in Madison. He is Dr. R. O. Swann, who has been an assistant professor in the department of obstetrics and gynecology at the University of Iowa College of Medicine. Doctor Swann received his medical education in the East, graduating from New York Medical College in 1947. After interning at Emanuel Hospital, Portland, Oregon, he began postgraduate work at Akron City Hospital, Ohio, was sent on affiliation to the Chicago Lying-In Hospital in 1950, served in the armed forces during the Korean conflict, and returned to complete his studies at the University Hospitals in Iowa City.

Another physician added to the staffs is Dr. J. D. Hare, previously associated with the pediatric staff of the University Hospitals in Iowa City. Besides a degree from Queen's University, Canada, received in 1950, Doctor Hare's medical background consists of an internship and one year of pediatric residency at the University of Western Ontario, and an additional three years of postgraduate work at Iowa City. Prior to completing his training, Doctor Hare practiced in the field of pediatrics for three years in British Columbia.

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DIMETANE Extentabs (12 mg. each, coated) provide antihistamine effects daylong or nightlong for 10-12 hours. Tablets (4 mg. each, scored) or pleasant-tasting Elixir (2 mg./5 cc.) may be prescribed t.i.d. or q.i.d., or as supplementary dosage to Extentabs in acute allergic situations. A. H. ROBINS CO., INC., Richmond 20, Virginia. Ethical Pharmaceuticals of Merit Since 1878.

*Sea food—source of highly potent allergens. Typical are: lobster; tuna; sturgeon roe; fish oil used to prepare leather, chamois, soaps; cuttlefish bone for polishing material and tooth powder; glues made from fish products.

New Appointment At Marquette

Dr. William W. Engstrom, an Associate Professor of Medicine at Marquette University School of Medicine, has been named the Francis D. Murphy Professor and Chairman of the Department of Medicine. On August 15 Doctor Engstrom assumed the post held by *Dr. Francis D. Murphy*, who will remain a professor in the department and active in the teaching program of the medical school. Doctor Murphy will also continue in the private practice of medicine.

The Francis D. Murphy chair of medicine, a $350,000 endowment, was established in January, 1957, by an anonymous Milwaukee industrialist, honoring Doctor Murphy for his 35 years of service to the school and community. Doctor Murphy himself never occupied the newly created chair. Doctor Murphy, upon his retirement as Professor and Chairman of the Department, recommended the appointee to a selection committee and to the Executive Faculty of the medical school. The appointment was approved by Rev. E. J. O'Donnell, S.J., President of the University.

Appointed Head of Hospital

The Milwaukee County Board of Public Welfare announced recently that *Dr. C. J. Buscaglia* has been named medical director of the county hospital for mental diseases. He succeeds Dr. C. W. Landis who became coordinator of the county division of mental health.

Doctor Scott Moves to Madison

In July Dr. John K. Scott joined *Dr. James F. Land* of Madison in the practice of otology, laryngology and rhinology. Formerly of Columbus, Ohio, Doctor Scott received his medical degree from Ohio State University in 1954, interned at White Cross Hospital, Columbus, and served a three-year residency at the University Hospitals there.

Dr. C. B. Larkin Begins Practice in Madison

Having recently completed a one-year fellowship in chest diseases at the Veterans Administration Hospital in Madison, *Dr. Charles B. Larkin* opened an office in Doctor's Park for the practice of internal medicine.

Doctor Larkin received his medical education in Madison, graduating from the University of Wisconsin Medical School in 1949, interning at Madison General Hosiptal, and serving a residency in internal medicine at St. Mary's Hospital. He was a member of the armed services during World War II and the Korean War.

In a recent 140-patient study[1] DIMETANE gave "more relief or was superior to other antihistamines," in 63, or 45% of a group manifesting a variety of allergic conditions. Gave good to excellent results in 87%. Was well tolerated in 92%. Only 11 patients (8%) experienced any side reactions and 5 of these could not tolerate any antihistamines.

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1. Thomas, J. W.: Ann. Allergy 16:128, 1958

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W. H. Wolberg, 1300 University Avenue, Madison.
C. C. Skinsnes, 414 West Decker Street, Viroqua.
R. N. Burch, Summit Hospital, Oconomowoc.
J. O. Simenstad, Osceola.
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D. A. Smith, Madison, to 218 East 19th Street, Fond du Lac.
T. C. Sweeney, Beloit, to 2020 East 93rd Street, Cleveland, Ohio.
E. C. Ferguson, North Miami, Florida, to 107 East Main Street, Juneau.
J. M. Grinde, De Forest, to Weyburn Union Hospital, Weyburn, Saskatchewan, Canada.
J. E. Steinhaus, Madison, to 1199 Oxford Road, N.E., Atlanta, Georgia.
J. H. Turgeson, Los Angeles, California, to 1922 University Avenue, Madison.
L. L. Allen, Cincinnati, Ohio, to 6117 Washington Avenue, Philadelphia, Pennsylvania.
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J. J. Sullivan, Appleton, to 2001 Linden Grove Way, Carmichael, California.
B. L. Fabric, Miami Beach, Florida, to 601 Palm Drive, Hallandale, Florida.
L. F. Jermain, Indianapolis, Indiana, to 3423 North Maryland Avenue, Milwaukee.
V. G. Ward, Madison, to Palisade, Nebraska.
T. C. Puchner, Milwaukee, to 1519 Adams Street, N.E., Minneapolis, Minnesota.
R. E. Johnson, Evanston, Illinois, to 425 East Wisconsin Avenue, Milwaukee.
P. E. Doermann, Milwaukee, to Jagaum Mission Hospital, Madang, Territory of New Guinea.
R. M. Newton, ** Madison, to Box 877, Narrows, Virginia.
A. H. Holt, Milwaukee, to 3031 Market Street, Youngstown, Ohio.
G. B. Theil, Appleton, to 17380 Via San Ardo, San Lorenzo, California.
L. L. Thompson, West Allis, to St. Vincent's Hospital, Green Bay.
R. R. Rivard, Neopit, to Holyoke Hospital, Holyoke, Massachusetts.
Wallace Marshall, Two Rivers, to Watertown.
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PHENAPHEN In each capsule

Acetylsalicylic Acid 2½ gr. . (162 mg.)
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Phenobarbital ¼ gr. . . . . (16.2 mg.)
Hyoscyamine sulfate . . . . . (0.031 mg.)

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OBITUARIES

Dr. H. C. Dallwig, of Milwaukee, passed away April 30 at the age of 67.

A native of Milwaukee, Doctor Dallwig graduated from the University of Wisconsin in 1914. He served an assistantship in pharmacology and toxicology from 1914–1915 under Dr. Arthur S. Loevenhart from which he received a master of science degree. He received his medical degree from Harvard Medical School in 1917. Following an internship at Milwaukee County Hospital, he served in the U.S. Army for one year before beginning practice in Milwaukee as an internist. Later he worked as a radiologist at Muirdale Sanitorium and at County Emergency Hospital.

In 1936, Doctor Dallwig started a pioneering effort to establish prepaid medicine with the opening of the Milwaukee Medical Center. When Blue Cross and Blue Shield Plans were developed along with other insurance plans, Doctor Dallwig abandoned his effort and discontinued the Center.

Memberships held by Doctor Dallwig included those with the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, the American Medical Association, and the Milwaukee Academy of Medicine.

Doctor Dallwig is survived by his widow, Grace, and two daughters.

Dr. F. F. Newell, 78, died at his Burlington home on May 26 following a short illness. He had practiced in that city for 58 years.

Doctor Newell was born in 1879 at Waterford. The fifth generation of his family to enter the medical profession, Doctor Newell received his medical degree from Northwestern University at the age of 20. Prior to locating in Burlington, he did postgraduate work in Chicago and practiced a short time in Racine and Waukesha. In 1953 the Burlington Kiwanis Club honored him for serving the community for more than 50 years.

Previously Doctor Newell was a member of the Walworth County Medical Society, the State Medical Society of Wisconsin and its Fifty Year Club, and a life member of the American Medical Association.

Surviving are his widow, two sons and a daughter.

Dr. R. Y. Wheelihan, a former practitioner in Elm Grove and Milwaukee, died June 25 in Riviera Beach, Florida. He was 54 years of age.

Doctor Wheelihan graduated from Northwestern University School of Medicine in 1928, interned at Milwaukee Hospital and Milwaukee Children's Hospital, and served a residency at Children's Memorial Hospital in Chicago. After being located in the Milwaukee County area for 18 years, he moved to West Palm Beach, Florida, in 1950.

He was a former member of the Medical Society of Milwaukee County, Milwaukee Academy of Medicine and the State Medical Society of Wisconsin. Doctor Wheelihan was secretary of the Palm Beach County Medical Society and vice-president of the St. Mary's Hospital staff, West Palm Beach, at the time of his death.

His widow, three sons, and three daughters survive.

Dr. C. J. Becker, a Milwaukee general practitioner for 42 years, succumbed July 4. He was 74 years of age.

Born in Milwaukee in 1883, Doctor Becker spent virtually his entire life there. In 1916 he graduated from Marquette University School of Medicine and immediately opened an office in Milwaukee. In addition to his private practice he was affiliated with the medical school at Marquette, instructing in the physiology, pharmacology and pediatrics departments. From 1917 to 1922 he also served as medical superintendent of the Marquette Dispensary Clinic.

Doctor Becker was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include his widow, Marie, and two daughters.

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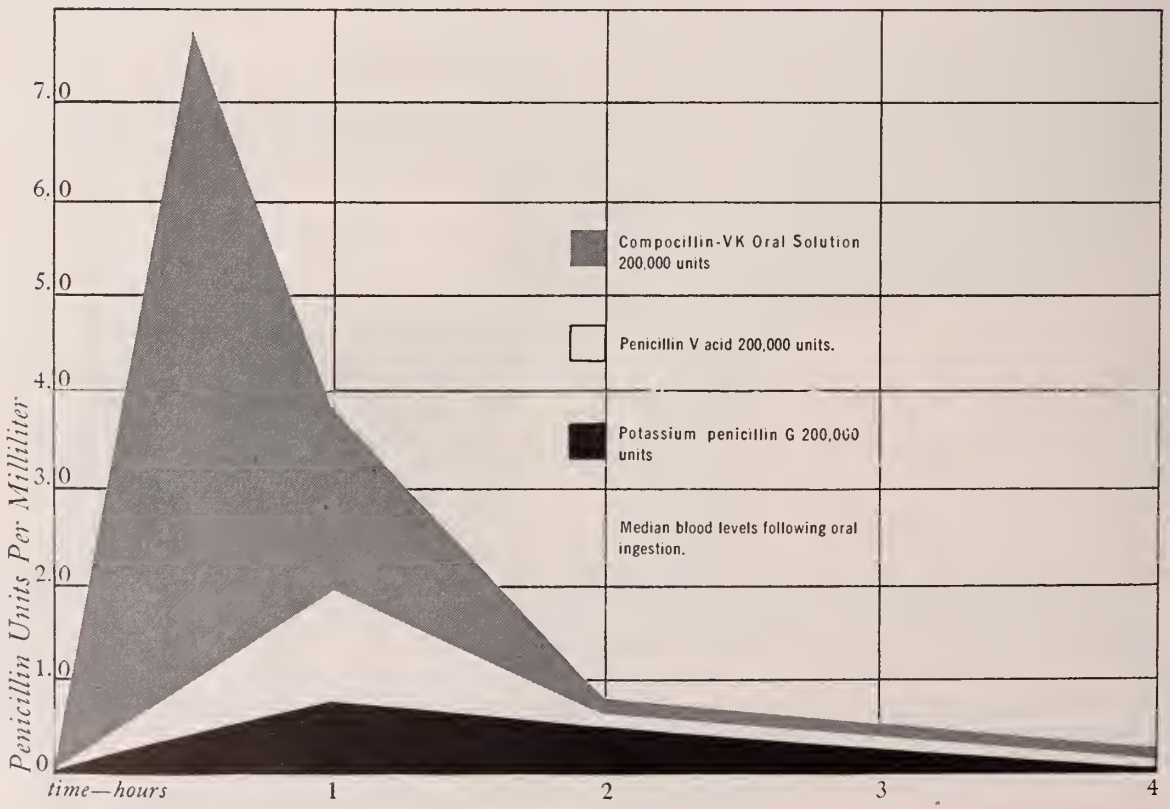
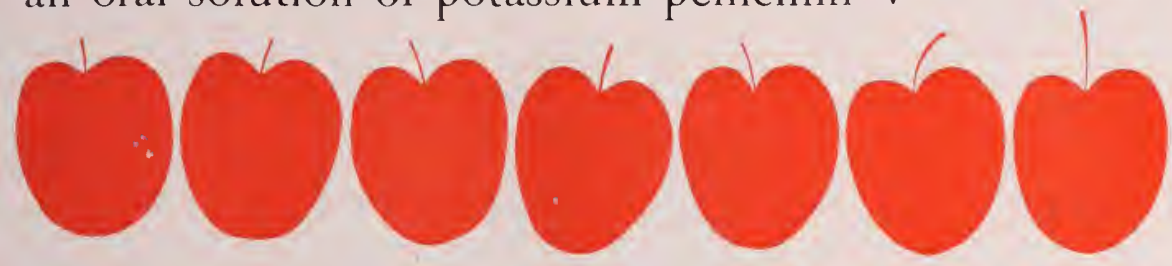
Good-tasting, cherry-flavored . . .



an oral solution of potassium penicillin V



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The initial recommended dose: In acute infections, the range is from 125 mg. (200,000 units) three times daily to 250 mg. (400,000 units) every four hours. For young children, the adult dose may be reduced in proportion to age and weight. For prophylactic use, 125 mg. (200,000 units) may be administered once or twice daily.

COMPOCILLIN-VK Granules for Oral Solution come in 40-cc. and 80-cc. bottles. Each 5-cc. teaspoon of the reconstituted solution represents 125 mg. (200,000 units) of potassium penicillin V. The dry granules stay stable under ordinary room temperatures. When reconstituted, the solution will remain potent for two weeks under refrigeration.

Abbott

CORRESPONDENCE

Dear Editor:

Preliminary findings in the City Health Department research study of 400 Madison school children to determine the incidence of Group A beta hemolytic Streptococcus are as follows (per cent positive at any one time):

December 1957	12.62%
January 1958	22.00
February 1958	22.22
March 1958	20.87
April 1958	20.67
May 1958	25.03
June 1958	20.80

Funds to repeat the study another year have been requested of the National Heart Institute. The patience and cooperation of Madison physicians as well as of the Madison families of the above children were vital to assembly of the above data. The Health Department is grateful.

CHARLES K. KINCAID, M.D.
Health Commissioner

Dear Editor:

The American College of Chest Physicians, an organization comprised of 6403 physicians in 89 countries and territories throughout the world, met in annual session in San Francisco June 18–22. Executive Council passed the following resolution:

"In view of the vital interest in improving public health and welfare, and in the eradication of diseases of the chest in particular, our position regarding the use of BCG (bacillus Calmette-Guerin) against tuberculosis in the United States should be made known. At the present time, there is insufficient evidence that significant protection is afforded by its use. The Council fully endorses the antituberculosis control program of the U.S. Public Health Service, which includes research in BCG, and urges the continued support of their program."

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Gallbladder Surgery, Three Days, November 3
Surgery of Hernia, Three Days, November 6
General Surgery, Two Weeks, November 10; One Week, October 27
Fractures & Traumatic Surgery, Two Weeks, October 20
American Board Review Course, Two Weeks, November 10
Blood Vessel Surgery, One Week, October 20
GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, Two Weeks, September 8
Vaginal Approach to Pelvic Surgery, One Week, October 6
General & Surgical Obstetrics, Twn Weeks, September 22
MEDICINE—General Review Course, Two Weeks, October 20
Electrocardiography, Two-Week Basic Cnurse, October 6
Gastrnscopy & Gastroenterology, Two Weeks, November 3
American Board Review Course, One Week, September 29 (For Part I Candidates Only)
DERMATOLOGY—Clinical & Didactic Course, Two Weeks, November 3
UROLOGY—Two-Week Intensive Course, October 13
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SUPPLIED: Capsules, bottles of 36. Each capsule contains 62.5 mg. (100,000 units) of penicillin V, 194 mg. of salicylamide, 6.25 mg. of promethazine hydrochloride, 130 mg. of phenacetin, and 3 mg. of mephentermine sulfate.

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*Morrison, L. F.: Arch. Otolaryng. 59:48-53 (Jan.) 1954.

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Phenylpropanolamine hydrochloride	50 mg.
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Dosage: 1 tablet in the morning, mid-afternoon, and in the evening, if needed. To be swallowed whole to preserve the timed-release feature.

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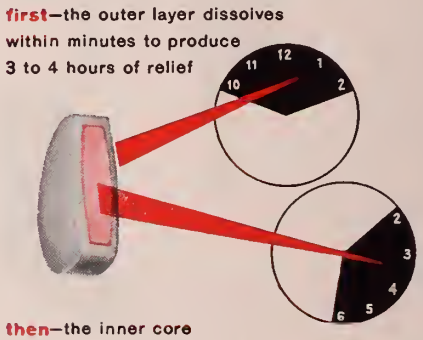

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INTOLERANCE TO ORAL IRON:

"...she had an excellent response with a reticulocyte peak of 5.3 per cent on the seventh day, and a complete disappearance of the anemia and conversion from hypochromic to normochromic cells by the end of two months. She experienced remarkable improvement in pep and sense of well-being coincident with the alleviation of her anemia."[2]

(1) Hagedorn, A. B.: Proc. Staff Meet. Mayo Clin. **32**:705 (Dec. 11) 1957.
(2) Best, W. R.; Louis, J., and Limarzi, L. R.: M. Clin. North America (Jan.) 1958, p. 3.

Supplied: 2-cc. and 5-cc. ampuls, boxes of 4. Physician's directions in every box. There are 50 mg. of elemental iron per cc. Request brochure NDA 17, Imferon.

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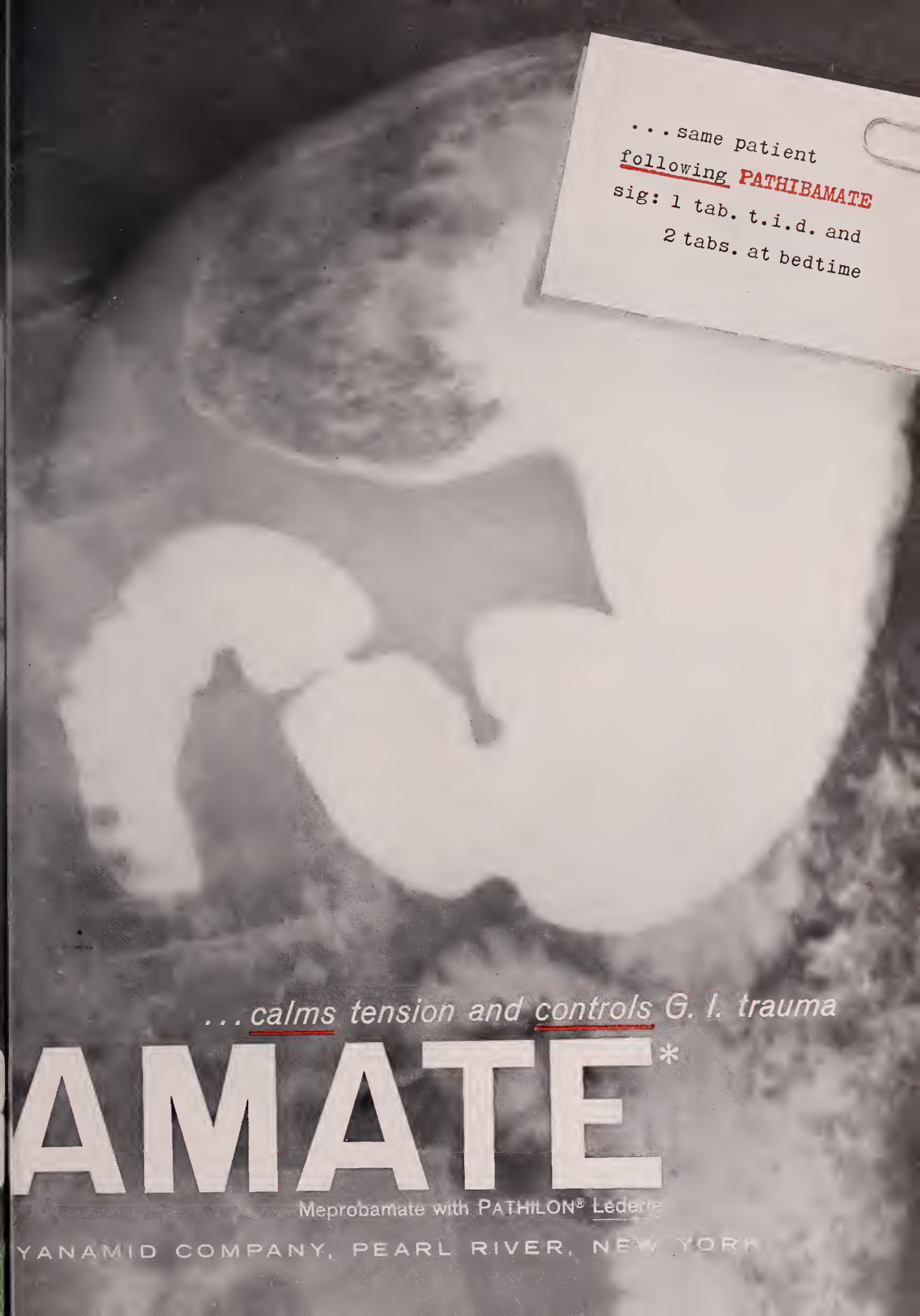
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See
MD
Medical Newsmagazine,
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Pages 76 – 77.

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THURSDAY, OCTOBER 2

Wausau, Wausau Club. Same as at Eau Claire previous day. (Meeting of Ninth Councilor District.)

WEDNESDAY, OCTOBER 8

Janesville, Mercy Hospital. Afternoon and evening program on orthopedics, proctology, cardiology, and internal medicine. $8.00 including dinner. 5 hours AAGP Category I credit.

THURSDAY, OCTOBER 9

Neenah, Theda Clark Hospital. Same program as in Janesville, only condensed into afternoon from 2:00 to 6:00 p.m. $5.00 registration. 4 hours AAGP Category I credit.

THURSDAY, OCTOBER 16

Sheboygan, St. Nicholas' Hospital. Afternoon program from 2:00 to 6:00 p.m. $5.00. 4 hours AAGP Category I credit. Full hour of identifying varying heart murmurs, allergies in children, obstetrics, psychiatry.

WEDNESDAY, OCTOBER 22

Marinette, Riverside Country Club, Menominee, Mich. Program during afternoon and evening following dinner. $8.00 including dinner. 5 hours AAGP Category I credit. Medical and surgical aspects of thyroid disease, obstetrics, office ophthalmology.

THURSDAY, OCTOBER 23

Rhinelander, St. Mary's Hospital (Dinner in Fenlon Hotel). Same as at Marinette previous day.

FRIDAY, OCTOBER 24

Superior, St. Mary's Hospital (Dinner at Hotel Superior). Same as at Marinette and Rhinelander two previous days.

WEDNESDAY, OCTOBER 29

Madison, Wisconsin General Hospital (Room 300). Afternoon program 2:00 to 6:00 p.m. $5.00. 4 hours AAGP Category I credit. Cardiology, aseptic meningitis, pediatric surgery, gastroenterology.

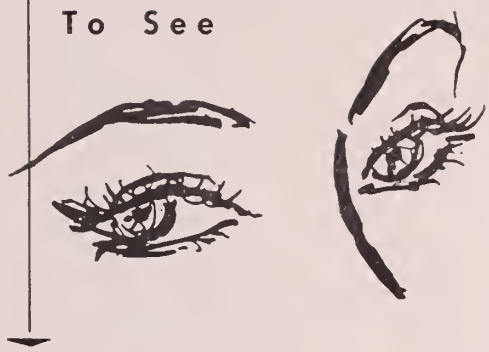
THURSDAY, NOVEMBER 20

Stevens Point, Hardware Mutuals Auditorium. Afternoon program from 2:00 to 6:00 p.m. $5.00. 4 hours AAGP Category I credit. Fever of unknown origin, common neurologic problems, common skin diseases, gynecology.

* * *

To assist with plans for each meeting, especially with associated dinners, please make reservations in advance. Refunds will be made in event of cancellations received prior to the meeting date. Make checks payable to: State Medical Society of Wisconsin, and mail to Box 1109, Madison 1, Wisconsin.

The Man To See



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Eye Physicians have proved that Uhlemann skill and experience help to assure a satisfied clientele.

Close co-operation with the Eye-Physician, supported by a sincere admiration for the value of his services, will continue to be the guiding principle of the Uhlemann Optical Company.

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in potentially
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Make new

Panalba*

(PANmycin† Phosphate plus ALBAmycin**)

your broad-spectrum antibiotic of first resort

effective against more than 30 common pathogens, even including resistant staphylococci.

Available forms:

1. Panalba Capsules, bottles of 16 and 100 capsules. Each capsule contains:

Panmycin phosphate (tetracycline phosphate complex) equivalent to tetracycline hydrochloride . . . . . 250 mg.
Albamycin (as novobiocin sodium) 125 mg.

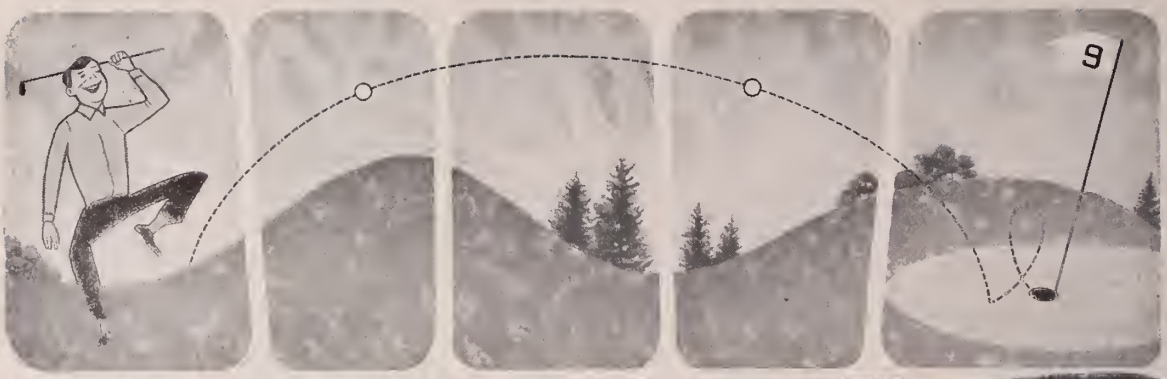
2. Panalba KM,†† Flavored Granules, 60 cc. size bottle. When sufficient water is added to fill the bottle, each teaspoonful (5 cc.) contains:

Panmycin (tetracycline) equivalent to tetracycline hydrochloride 125 mg.
Albamycin (as novobiocin calcium). 62.5 mg.
Potassium metaphosphate . . . . . 100 mg.

Dosage

Panalba Capsules
Usual adult dosage is 2 capsules q.i.d.

Panalba KM Granules
For the treatment of moderately acute infections in infants and children, the recom- [illegible] is 1 teaspoonful per 15 to [illegible] of body weight per day, administered [illegible] 4 equal doses. Severe or prolonged [illegible] require higher doses. Dosage for [illegible] to 4 teaspoonfuls 3 or 4 times daily [illegible] severity of the in- [illegible]



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cough sedative / antihistamine / expectorant

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Each teaspoonful (5 cc.) contains:

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Dihydrocodeinone Bitartrate (Warning: May be habit-forming)	5 mg.	6.5 mg.
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Pyrilamine Maleate		12.5 mg.
Ammonium Chloride		60 mg.
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PRONOUNCED TAY-O

(brand of triacetyloleandomycin with gluCOSAmine)

Capsules / Oral Suspension

designed for effective control of common gram-positive infections

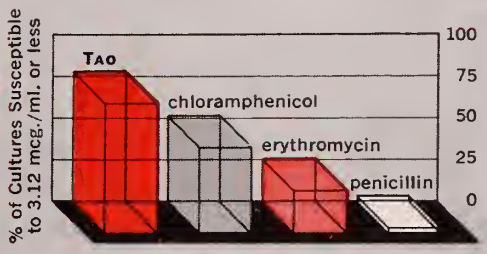
effective . . .

CLINICAL RESULTS	adults	children	all Staph infections
Cured	172 (80%)	148 (89%)	71 (88%)
Improved	28 (13%)	8 (5%)	7 (9%)
Failure	17 (7%)	11 (6%)	3 (3%)

Types of infecting organisms: The majority of identified etiologic microorganisms were Staph. aureus and Staph. albus. TAO has its greatest usefulness against organisms such as: staphylococci (including strains resistant to other antibiotics), streptococci (beta-hemolytic strains, alpha-hemolytic strains and enterococci), pneumococci, gonococci, Hemophilus influenzae.

even against resistant staph[1,2] . . .

Per cent of "antibiotic-resistant" epidemic staphylococci cultures susceptible to TAO, erythromycin, penicillin and chloramphenicol.[1]



well tolerated . . .

REACTIONS:

(a) adults	(b) children
Total—9.2% (20 out of 217)	Total—0.6% (1 out of 167)
Skin rash—1.4% (3 out of 217)	Skin rash—none
Gastrointestinal—7.8% (17 out of 217)	Gastrointestinal—0.6% (1 out of 167)

There was complete freedom from adverse reactions in 94.5% of all patients. Side effects in the other 5.5% were usually mild and seldom required discontinuance of therapy.

plus . . . stability in gastric acid • rapid, high and sustained blood levels • high urinary concentrations • outstanding palatability in a liquid preparation

Dosage and Administration: Dosage varies according to the severity of the infection. For adults, the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. For children 8 months to 8 years of age, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective. Since TAO is therapeutically stable in gastric acid, it may be administered at any time, without regard to meals.

Supplied: TAO Capsules—250 mg. and 125 mg.; bottles of 60. TAO for Oral Suspension—1.5 Gm.; 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

References: 1. English, A. R., and Fink, F. C.: Antibiotics & Chemother. (Aug.) 1958. 2. English, A. R., and McBride, T. J.: Antibiotics & Chemother. (Aug.) 1958. 3. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy (Aug.) 1958. 4. Celmer, W. D., et al.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 476.

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SCIENCE FOR THE WORLD'S WELL-BEING

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MEDICAL MEETINGS IN WISCONSIN AND SURROUNDING STATES

SEPTEMBER

American College of Physicians, Mid-West regional meeting, Milwaukee, Wisconsin, September 27.

American Medical Writers' Association, Hotel Morrison, Chicago, Sept. 26–27.

OCTOBER

American Academy of Ophthalmology and Otolaryngology, Palmer House, Chicago, Oct. 12–17. Dr. W. L. Benedit, 15 Second St., S.W., Rochester, Minn., Secretary. (Meeting open to residents only. Need letter of identification from superintendent of hospital. Scientific and technical exhibits. No charge.)

American Academy of Pediatrics, Palmer House, Chicago, Oct. 20–23. Dr. E. H. Christopherson, 1801 Hinman Ave., Evanston, Ill., Executive Secretary. (Meeting open to residents only. Need letter to identify as a *bona fide* resident. Scientific and technical exhibits. No charge.)

American Association for the Surgery of Trauma, Drake Hotel, Chicago, Oct. 2–4. Dr. William T. Fitts, Jr., 3400 Spruce St., Philadelphia 4, Secretary.

American College of Surgeons, Oct. 6–10. Dr. Michael L. Mason, 40 E. Erie St., Chicago, Secretary.

American Society of Plastic and Reconstructive Surgery, Drake Hotel, Chicago, Oct. 12–17. Dr. Kenneth L. Pickrell, Duke Univ. Hosp., Durham, N. C., Secretary.

Central Association of Obstetricians and Gynecologists, Hotel Leamington, Minneapolis, Oct. 2–4. Dr. Edwin J. DeCosta, 104 S. Michigan Ave., Chicago 3, Secretary.

Central Society for Clinical Research, Drake Hotel, Chicago, Oct. 31-Nov. 1. Dr. Austin S. Weisberger, 2065 Adelbert Rd., Cleveland 6, Secretary.

National Proctologic Association, Hamilton Hotel, Chicago, Oct., Dr. George E. Mueller, 59 E. Madison St., Chicago 2, Secretary.

Society for Clinical and Experimental Hypnosis, Morrison Hotel, Chicago, Oct. 29–31, Mr. Samuel Turiel, 750 N. Michigan Ave., Chicago, Administrative Secretary.

MISSISSIPPI VALLEY MEDICAL SOCIETY POSTGRADUATE ASSEMBLY IN CHICAGO

The Mississippi Valley Medical Society's twenty-third annual meeting will commence September 24 and continue through September 26 at the Hotel Morrison in Chicago, Illinois.

Dr. Gunnar Gundersen, President of the American Medical Association, La Crosse, will be the banquet speaker Thursday evening, September 25. Dr. Ben Peckham, Professor and Chairman of Obstetrics and Gynecology, University of Wisconsin Medical School, Madison, will be a member of a panel on menopause, menorrhagia and amenorrhea (menorrhagia), September 26.

Dr. J. K. Martins, Eau Claire, will be a scientific exhibitor on "Medical Responsibility in Skin Diving Accidents." Dr. Robert G. Zach, Monroe, will also be a scientific exhibitor on the Quincy Major Learning Program: "Lower Esophageal Rings and Differential Diagnosis in Dysphagia."

Dr. Arnold S. Jackson, Madison, is the Wisconsin vice president of the Mississippi Valley Medical Society officers for 1958. Dr. Wallace Marshall, Two Rivers, Dr. Edmund W. Schact, Racine, and Dr. Millard Tufts, Milwaukee, are 1958 members of the board of directors of the Society.

Wisconsin members of the advisory committee are: Dr. Ervin L. Bernhart, Milwaukee, Dr. Harry E. Kasten, Beloit, Dr. Arthur J. McCarey, Green Bay, and Dr. L. O. Simenstad, Osceola, who are all past presidents of the State Medical Society of Wisconsin.

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delicious cherry flavor— no unpleasant aftertaste

Average dosage is 1 teaspoonful daily. Available in bottles of 4 and 16 fl. oz.

Each teaspoonful (5 cc.) contains:

l-Lysine HCl	300 mg.
Vitamin B_{12} Crystalline	25 mcgm.
Thiamine HCl (B_1)	10 mg.
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Ferric Pyrophosphate (Soluble)	250 mg.
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Sorbitol	3.5 Gm.

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glucosamine potentiated tetracycline

CAPSULES (black and white)
250 mg., 125 mg.

ORAL SUSPENSION (orange flavored)
2 oz. bottle, 125 mg. per tsp. (5 cc.)

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10 cc., 5 mg. per drop (100 mg. per cc.)
Calibrated dropper

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glucosamine potentiated tetracycline with nystatin

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250 mg. Cosa-Tetracyn (with 250,000 u. nystatin)

ORAL SUSPENSION (orange-pineapple flavored) 2 oz. bottle, 125 mg. Cosa-Tetracyn (with 125,000 u. nystatin) per tsp. (5 cc.)

For patients susceptible to monilial superinfection.

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glucosamine potentiated tetracycline-analgesic-antihistamine compound

CAPSULES (black and orange)
each capsule contains:

Cosa-Tetracyn	125 mg.
Phenacetin	120 mg.
Caffeine	30 mg.
Salicylamide	150 mg.
Buclizine HCl	15 mg.

- Antibiotic
- Analgesic
- Antihistamine

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REFERENCES: 1. Carlozzi, M.: Ant. Med. & Clin. Therapy 5:146 (Feb.) 1958. 2. Welch, H.; Wright, W. W., and Staffa, A. W.: Ant. Med. & Clin. Therapy 5:52 (Jan.) 1958. 3. Walch, E.: Dent. Med. Wschr. (April) 1956. 4. Shalowitz, M.: Clin. Rev. 1:25 (April) 1958. 5. Nathan, L. A.: Arch. Pediat. 75:251 (June) 1958. 6. Cornbleet, T.; Chesrow, E., and Barsky, S.: Ant. Med. & Clin. Therapy 5:328 (May) 1958. 7. Stone, M. L.; Sedlis, A., Bamford, J., and Bradley, W.: Ant. Med. & Clin. Therapy 5:322 (May) 1958. 8. Harris, H.: Clin. Rev. 1:15 (July) 1958.

*Trademark

A-5365-7-8

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 15th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from individual members of the State Medical Society will be accepted without charge. The charge quoted previously applies to advertisements placed by clinics. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.

MEDICAL AND SURGICAL GROUP would like to form association with young doctor interested in one, two, or three year appointment as assistant in surgery, and to assist in the handling of emergency and industrial cases. Contact Box 736, in care of the Journal. 7–9

WANTED PEDIATRICIAN: Excellent opportunity for certified or board eligible pediatrician with established group in attractive Minnesota community. Medical Block Clinic, 412 Main St., Red Wing, Minn. p9–10

FOR SALE: 1 set Hamilton office furniture, reception room furniture, sterilizer, and surgical instruments all in very good condition. Will sell reasonable. Telephone 2131 or 2132, Neopit or write John Hogan, M.D., Neopit, Wisconsin. m9–10

PHYSICIAN NEEDED IMMEDIATELY: Thriving Wisconsin industrial and farming community of 1,200 with large surrounding area needs a physician immediately. New air conditioned clinic with large reception room, business office, 3 examining rooms and laboratory available for immediate occupancy. These facilities may be expanded as the need arises. Contact Box 752 in care of the Journal. 9–10

WANTED: Young, married general physician to join well-established 2-man group in Northwest Wisconsin resort and farming community of 3,000, located in trade area of 25,000. New, completely equipped clinic building. New, fully accredited 26-bed, 8-bassinet hospital 4 blocks away. Excellent salary, with partnership in one year if mutually agreeable. Address replies to Box 751 in care of the Journal. p9–11

FOR SALE: Diathermy instruments, cabinets, examining and office furniture. May be seen Saturdays. Robert A. Turcott, M.D., Lake Mills, Wisconsin. m9–11

FOR SALE: Picker Century X-ray with tilt table, bucky and fluoroscopy. $1,500 complete. Address inquiries to Robert A. Turcott, M.D., Lake Mills, Wisconsin. m9–11

WANTED: General practitioner for group of three in small southern Wisconsin town. Clinic facilities available. Young man preferred. Contact Box 741 in care of the Journal. m8–9

DOCTORS' OFFICE SPACE AVAILABLE in beautiful new Brentwood Medical Arts Building, 2018 North Sherman Avenue, Madison. Private doctors' parking, public parking (40 cars), acoustical ceiling, mahogany paneling, heat and air conditioning, large reception room, black top parking area, pharmacy in building. On bus line, convenient to schools and churches. Address replies to Box 715 in care of the Journal. tfn

FOR SALE: By widow of physician. Extensive, up-to-date medical library; 100 MA x-ray unit with fluoroscope; esophagoscope; spot film device; motor-driven Bucky table; also, Pelton sterilizer, proctoscope, floor model sphygmomanometer; sundry smaller items. Address replies to Box 746 in care of the Journal. m8–9

FOR SALE: 38-year-old successful clinic in west central Wisconsin, grossing $100,000 per year with more potential. Ideal arrangement for four physicians. Average 50 patients per day. 32-bed hospital operated in conjunction with clinic. Suitable brick building originally planned for clinic, with x-ray and ENT department. Situated in heart of Trempealeau county, prosperous rural area with great potential industrial development, covers area of 8,000 population, mostly Scandinavian, Polish and German, fine school, five churches, golf course, swimming pool, Scout organizations, good hunting, fishing. Sale made necessary because of two coronary attacks by owner, who prefers selling on a term basis. Contact Box 743 in care of the Journal. m8–9

FOR RENT: Physician office in business section of city of Brookfield, located on ground floor of clinic building, air conditioned, excellent location in rapidly growing prosperous area in which doctor is badly needed, office fully equipped, including 100 MA x-ray. Generous terms and area make this an unexcelled opportunity. Contact Box 753 in care of the Journal. m9–10

PHYSICIAN'S OFFICE SPACE AVAILABLE: Desirable location on ground floor; 3 consultation rooms; share waiting room with dentist; situated on Capitol Drive, Milwaukee, Wisconsin. Contact Box 742 in care of the Journal. 8–9

RADIOLOGIST: For Capitol Hospital, Milwaukee, Wisconsin. Contact: Administrator, Capitol Hospital, 1971 West Capitol Drive, Hilltop 2–9100, Milwaukee 6, Wisconsin. 8tfn

WANTED: A young man, preferably out of his internship, to join two men in general practice. One man, age 50, member of the American Academy of General Practice doing general surgery. Another man, age 40, as a partner. Begin on salary basis; if satisfied, work toward partnership. Contact Box 744 in care of the Journal. m8–9

WANTED: Young physician to practice General Practice with a small group, consisting of a General Practitioner with an established practice of 30 years duration, plus a board certificate surgeon. Initial salary open. Desire is for early partnership. Contact Box 745 in care of the Journal. m8–9

FOR SALE: By widow of physician. Equipment of a private office, treatment room, laboratory, waiting room; also an extensive library. Contact Kenneth Kenney, Attorney, 225 East Mason Street, Milwaukee 2, Wisconsin, telephone BRoadway 1–1311. m9–10

WANTED GENERAL PRACTITIONER: General practitioner in Northwest Wisconsin desires association of a physician. Good hospital facilities. Address replies to Box 748 in care of the Journal. m8–9

FOR SALE: Standard 100 m.a. x-ray machine, fully equipped. Contact N. W. Erickson, M.D., FU 6–4901, Juneau, Wisconsin. m8–9

ORTHOPEDIST: Wisconsin graduate, now associated with Class A Medical School, is interested in locating in Wisconsin. Board Member. Association with group of other Board member desired. Write Box 749 in care of the Journal. 8–10*

WANTED: YOUNG GENERAL PRACTITIONER needed in Oconto Falls or Gillett, Wis. Cities of 2,100 and 1,500 population. The three doctors serving these communities and surrounding rural area of 12,000 population desire another physician in the area. Oconto Falls has community-owned, 37-bed hospital. Progressive cities with many shopping, entertainment, and social facilities. Opportunity to practice with congenial professional association. Address replies to J. R. Culver, M.D., or C. E. Siefert, M.D., Oconto Falls, Wis. m8tf

THE PRACTICE OF A. F. RHEINECK, Suite 310, 2218 North Third Street, Milwaukee, Wisconsin, is immediately available to a qualified practitioner; equipment may also be purchased. All interested parties contact Attorney William E. Glassner, Jr., 2218 North Third Street, Milwaukee, Wisconsin, FRanklin 4–0790. p8,tf

WANTED: Psychiatrists or young doctors interested in psychiatry to work at Mendota State Hospital. These positions are permanent and under Civil Service, salary depends upon previous experience and training. Housing available on grounds. Contact Dr. W. J. Urben, Superintendent, Madison 4, Wisconsin. 8–12

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Monilial
overgrowth
is a factor

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SUPPLIED:
CAPSULES contain 250 mg. tetracycline HCl equivalent (phosphate-buffered) and 250,000 units Nystatin. ORAL SUSPENSION (cherry-mint flavored) Each 5 cc. teaspoonful contains 125 mg. tetracycline HCl equivalent (phosphate-buffered) and 125,000 units Nystatin.

DOSAGE:
Basic oral dosage (6-7 mg. per lb. body weight per day) in the average adult is 4 capsules or 8 tsp. of ACHROSTATIN V per day, equivalent to 1 Gm. of ACHROMYCIN V.

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Combines ACHROMYCIN V with NYSTATIN

ACHROSTATIN V combines ACHROMYCIN† V... the new rapid-acting oral form of ACHROMYCIN† Tetracycline, noted for its outstanding effectiveness against more than 50 different infections... and NYSTATIN, the antifungal specific. ACHROSTATIN V provides particularly effective therapy for those patients who are prone to monilial overgrowth during a protracted course of antibiotic treatment.

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BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interests of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison 6, Wisconsin.

A Primer on Common Functional Disorders. By Jack W. Fleming, M.D., Department of Internal Medicine, The Medical Center Clinic, Pensacola, Florida. Boston and Toronto, Little, Brown and Company, 1958. Price $5.

This book on the whole accomplishes what its author intended to do, which was to provide a simple framework within which to consider some of the common disorders occurring as parts of emotional disturbances and to suggest means of dealing with them by nonpsychiatrist physicians. The conditions particularly considered are the hyperventilation syndrome, various forms of headache, the gastric acidity syndrome and peptic ulcer, the irritable gastrointestinal tract, obesity, some allergic syndromes, backache, and menopausal symptoms and premenstrual tension.

There are good brief discussions of the physiological changes which are responsible for the actual symptoms in many of these conditions, and there is therefore a wholesome emphasis on the fact that the latter are actually disturbances in a human body, and not in some sort of disembodied "mind". This approach is also a highly desirable corrective to the common tendency to lump all emotionally conditioned symptoms together as "functional", without even asking where and what the functional changes are. One could wish, however, that the author, having correctly indicated that the terms "functional" and "organic" may frequently be misleading or useless, and having shown that they do not have any necessary connection with the concepts "psychogenic" or "emotional", had not nevertheless continued to rely heavily on them.

The book should certainly help in the recognition of the syndromes with which it deals and in an understanding of some aspects of their etiology and pathogenesis. There is very little discussion of emotional problems as seen in psychodynamic terms. The suggestions for treatment seem sound, although it is hard to know whether the necessarily brief descriptions of psychotherapeutic maneuvers will prove adequate for physicians without opportunity for some sort of supervised learning experience with them.—D. T. G.

* * *

Laboratory Medicine—Hematology. By John B. Miale, Professor of Pathology, University of Miami School of Medicine, and Director of Clinical Pathology, Jackson Memorial Hospital, Miami, Florida. St. Louis, The C. V. Mosby Company, 1958.

This is a volume on the laboratory aspects of disorders of the blood. The author has based his presentation on an extensive review of the literature, and there are numerous references conveniently grouped at the end of the chapters. In addition to the conventional descriptions of the morphology of the blood, the author has included informative material about phase microscopy, supravital staining, a short unit on electron microscopy, and a good deal of information on some of the other techniques which have added to information in hematology in recent years. There are descriptions of the use of radioactive chromium for survival studies and the use of paper electrophoresis for the study of hemoglobins and other proteins.

The book is profusely illustrated, with, among other things, five color plates. One might question the value of a number of the illustrations. It is not clear to the reviewer why there should be figures of a nomograph for computing relative centrifugal force or pictures of a microhematocrit or of a model of an electrophoresis device.

A second shortcoming in the eyes of this reviewer is the fact that the numerous references are not referred to in the text. The choice of references at the end of chapters seems to be excellent, but one does not find in the text specific references to the literature.

The book appears to be well written, well constructed, and certainly carefully planned. It contains 735 pages and is priced at $13.75.—R. F. S.

* * *

The Medical Department of the United States Army, Preventive Medicine in World War II, Volume Two, Environmental Hygiene. Edited by Colonel John Boyd Coates, Jr., MC, and Ebbe Curtis Hoff, Ph D., M.D. Washington, D. C., Office of the Surgeon General, Department of the Army, 1955. (For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D. C. Price $3.50)

This book is exclusively concerned with the experiences of the Army in the area of environmental hygiene during World War II. It is divided into nine chapters dealing with food management, housing, water purification, waste disposal, control of insects, rodent control, research background of insect and rodent control, foreign quarantine, and preventive medicine in ports of embarkation and for persons in transient. These titles suggest the type of material covered.

It should be of interest primarily to those people in public health or military activities whose concern is for large numbers of people and the handling of environmental problems. For these groups, this experience will serve as a valuable source of information, not only for the result of regular control programs but for research into new testing methods and compounds.—A. E.

The Medical Department of the United States Army, Preventive Medicine in World War II, Volume Three, Personal Health Measures and Immunization. Edited by Colonel John Boyd Coates, Jr., MC, and Ebbe Curtis Hoff, Ph.D., M.D. Washington, D.C., Office of the Surgeon General, Department of the Army, 1955. (For sale by the Superintendent of Documents, U S. Government Printing Office, Washington 25, D.C. Price, $3.25.)

The experience of the United States Army in the area of personal measures and immunization is carefully reviewed in this 394-page book. There are eight main chapters organized as follows: Chapter 1 deals with manpower selection and the overall preventive medicine program of the Army. Chapter 2 deals with personal hygiene in different overseas theaters and the educational and training program that was used in this regard. Chapter 3 has to do with clothing; Chapter 4, with nutrition; and Chapter 5, with malnutrition and deficiency diseases. These three chapters will be of interest to those concerned with special problems in difficult areas of the world, particularly from the standpoint of nutrition and deficiency diseases under unusual circumstances and special requirements for clothing in hot and cold climates. Chapter 6 will be of interest to many physicians as it deals with the Army experience in preventive psychiatry and the administrative management of a program of prevention. Some of the programs outlined will be of interest not only in case of future conflicts but also to large organizations in industry who are becoming increasingly concerned with mental hygiene programs. Chapter 7 is concerned with accidental trauma and is written by Major Edgar Cook and Doctor John Gordon, Professor of Medicine and Epidemiology at Harvard. This fine chapter reviews the importance of nonbattle injuries to the military and is a good epidemiological review of the situation. Chapter 8 reviews in detail the aims, objectives, and accomplishments of the Army immunization program. Details of preparation and administration of vaccine are given, and an attempt of evaluation of its effectiveness is made. This program will be of special interest to public health authorities. Included at the end of the book are tables dealing with the administrative requirements for yellow fever, cholera, typhus, and an extensive table indicating need for various immunizations in different sections of the world. Such information might be an important guide for the physician concerned with patients who wish to travel overseas.—A. E.

* * *

Ciba Foundation Symposium on Chemistry and Biology of Mucopolysaccharides. By. G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch. and Maeve O'Connor, B.A., editors for the Ciba Foundation. Boston, Little, Brown and Company, 1958. Price $8.50.

The fourteenth and most recent conference sponsored by the Ciba Foundation on the chemistry and biology of mucopolysaccharides has served to bring together most of the noteworthy workers in this area. Seventeen chapters have been contributed. At the end of each is a record of a discussion period dealing with the paper just presented.

The topics covered entail a multitude of organic and physiochemical and biological problems. They include biosynthesis, chemical genetics, serological reactions, pathological functions and pathological phenomena of these substances.

The subjects are generally treated in a highly detailed and specific manner. This book is thus designed for the advanced student in this area and will serve to bring him abreast with most of the more recent researches and advances in this rapidly growing field. It will be of particular value to the more biologically inclined investigators of mucopolysaccharide phenomena in terms of the various writers constantly attempting to related chemical structure to biological activity.—H. F. D.

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The Medical Library Service has announced that a new list of additions to the University Medical Library and the Medical Library Service is now available. Copies have already been sent to physicians on the mailing list of the library.

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* * *

The State Medical Society of Wisconsin is a contributor to the library. All of the current medical journals received on an exchange basis by the Society and the medical text books received and reviewed in The Journal Bookshelf, are given to the Medical Library Service and then become available to any physician in Wisconsin who indicates his desire to use them. All that is required is for the physician to advise the Medical Library Service that he wishes a loan packet on the specific subject he wishes to study. Packets, for example, may be obtained on: acute appendicitis, treatment of fractures of femur, medical or surgical treatment of ulcers, poisons in industry and many others.

When writing for a loan packet, address as follows: Medical Library Service, Service Memorial Institutes Building, North Charter Street, Madison 6, Wisconsin.

NEW BOOKS AVAILABLE

Since the organization of the reviewing arrangements was being revised at the time the following books were received by the Journal, reviews of them did not appear in "The Journal Bookshelf". They have, however, been added to the Medical Library Service collection and are available for loan in the state:

* * *

Arthritis Exposed; for its millions of victims and for others who wish to prevent it. By Millard Tufts, M. D., Milwaukee, Wisconsin. Illustrated by Tom Landsiedel. Milwaukee, Wisconsin, Olsen Publishing Company, 1956. Price $1.50.

Chemosurgery in Cancer, Gangrene and Infections, Featuring a New Method for the Microscopically Controlled Excision of Cancer. By Frederic E. Mohs, B. Sc., M. D., Associate Professor of Chemosurgery, Department of Surgery, University of Wisconsin Medical School; Head of the Chemosurgery Clinic, State of Wisconsin General Hospital; Research Associate, McArdle Memorial Laboratory for Cancer Research, Madison, Wisconsin. Springfield, Illinois, Charles C. Thomas, 1956. $13.50.

The Ciba Collection of Medical Illustrations, Volume 3. A Compilation of Paintings on the Normal and Pathologic Anatomy of the Digestive System. Part III, Liver, Biliary Tract and Pancreas. Prepared by Frank H. Netter, M. D., edited by Ernst Oppenheimer, M. D. 1957. Price $10.50.

Clinical Examinations in Neurology. By Members of the Sections of Neurology and Section of Physiology, Mayo Clinic and Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota, Rochester, Minnesota. Philadelphia and London, W. B. Saunders Company, 1956.

Clinical Recognition and Management of Disturbances of Body Fluids. By John H. Bland, M. D., Associate Professor of Medicine, University of Vermont College of Medicine. Second Edition. Philadelphia and London, W. B. Saunders Company, 1956. Price $11.50.

Electrocardiography; Fundamentals and Clinical Application. By Louis Wolff, M. D.; Visiting Physician, Consultant in Cardiology, and Chief of the Electrocardiographic Laboratory, Beth Israel Hospital; and Assistant Clinical Professor of Medicine, Harvard Medical School. Second Edition. Philadelphia and London, W. B. Saunders Company, 1956. Price $7.00.

The Management of Menstrual Disorders. By C. Frederic Fluhmann, B. A., M. D., C. M., Clinical Professor of Obstetrics and Gynecology, Stanford University School of Medicine, San Francisco, California; Assistant Visiting Obstetrician and Gynecologist, Stanford–Lane Hospitals; Courtesy Staff, Children's and Mount Zion Hospitals, San Francisco, California; Fellow, American Gynecological Society; Past President, San Francisco Gynecological Society and Pacific Coast Obstetrical and Gynecological Society. Philadelphia and London, W. B. Saunders Company, 1956. Price $8.50.

The Morphology of Human Blood Cells. By L. W. Diggs, M. A., M. D., Professor of Medicine and Director of Medical Laboratories, University of Tennessee and City of Memphis Hospitals, Consultant in Hematology, Armed Forces Institute of Pathology, Washington, D. C.; Dorothy Sturm, Instructor, Memphis Academy of Arts; and Ann Bell, B. A., Instructor in Medicine, University of Tennessee. Philadelphia and London, W. B. Saunders Company, 1956. Price $12.00.

Physical Diagnosis. By Ralph H. Major, M. D., professor of medicine and of the history of medicine, The University of Kansas; and Mahlon H. Delp, M. D., professor of medicine, The University of Kansas. Fifth Edition, Illustrated. Philadelphia and London, W. B. Saunders Company, 1956. Price, $7.00.

The Recovery Room—Immediate Postoperative Management. By Max S. Sadove, M. D., Professor of Surgery (Anesth.) and Head, Division of Anesthesiology, University of Illinois College of Medicine and the Research and Educational Hospitals; and James H. Cross, M. D., Clinical Assistant Professor in Surgery, University of Illinois College of Medicine. Philadelphia and London, W. B. Saunders Company, 1956. Price $12.00.

Roentgen Signs in Clinical Diagnosis. By Isadore Meschan, M. A., M. D., Professor and Director of the Department of Radiology at the Bowman Gray School of Medicine of Wake Forest College, Winston–Salem, North Carolina, and formerly Professor and Head of the Department of Radiology at the University of Arkansas School of Medicine, Little Rock, Arkansas; with the assistance of R. M. F. Farrer–Meschan, M. B., B. S. (Melbourne, Australia). Philadelphia and London, W. B. Saunders Company, 1956. Price, $20.00.

Rypins' Medical Licensure Examinations; Topical Summaries and Questions. Edited by Walter L. Bierring, M. D., M.A.C.P., M.R.C.P., Edin. (Hon.), Former Member, National Board of Medical Examiners, American Board of Internal Medicine, Iowa State Board of Medical Examiners; Iowa State Commission of Health; Professor Emeritus, Theory and Practice of Medicine; College of Medicine, State University of Iowa; Secretary, Federation of State Medical Boards of the United States; Chairman (Hon.), 1933–53, American Board of Preventive Medicine, Inc.; Director, Division Gerontology, Heart and Chronic Diseases, Iowa State Department of Health, with the collaboration of a review panel. Eighth Edition. Philadelphia and Montreal, J. B. Lippincott Company, 1957. Price, $10.00.

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List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland–Bayfield–Iron	H. V. Sandin 220 Seventh W., Ashland	C. A. Grand 520 W. Second, Ashland	
Barron–Washburn–Sawyer–Burnett	C. J. Strang Barron	H. M. Templeton Barron	Second Tuesday 7:30 p.m.
Brown	George Nadeau 128 E. Walnut, Green Bay	Frank Urban 305 E. Walnut, Green Bay	Second Thursday°
Calumet	J. R. Goelz Brillion	J. W. Knauf Chilton	
Chippewa	B. J. Haines Cadott	R. L. Hendrickson 12 Third, Cornell	Second Tuesday
Clark	T. N. Thompson, Jr. Neillsville	H. M. Braswell, Jr. Owen	
Columbia–Marquette–Adams	H. A. Winkler 115 W. Chestnut, Pardeeville	T. S. Westcott Pardeeville	Every Third Month 7:00 p.m.
Crawford	O. E. Satter Prairie du Chien	H. L. Shapiro Prairie du Chien	Third Wednesday
Dane	T. J. Nereim 3710 Spring Trail, Madison	A. P. Schoenenberger 122 W. Washington, Madison	Second Tuesday Sept. through June
Dodge	R. F. Boock 119½ Front, Beaver Dam	G. C. Drescher 106½ Front, Beaver Dam	Last Thursday°
Door–Kewaunee	J. F. March 413 4th, Algoma	A. S. Lanier 3rd & Ellis, Kewaunee	
Douglas	R. T. Anderson 1507 Tower, Superior	L. R. Rosin 2231 E. Fifth, Superior	First Wednesday°° Hotel Superior
Eau Claire–Dunn–Pepin	D. M. Willison 314 E. Grand, Eau Claire	K. E. Walter 131 S. Barstow, Eau Claire	Last Monday
Fond du Lac	John C. McCullough 20 Forest, Fond du Lac	R. W. Schroeder 330 Ledgeview, Fond du Lac	Fourth Thursday°
Forest	O. S. Tenley Wabeno	D. V. Moffet Crandon	
Grant	H. L. Doeringsfeld Platteville	H. W. Carey Lancaster	Last Thursday, March, June, Sept. and Nov.
Green	L. G. Kindschi 1770 13th, Monroe	J. A. Frantz Monroe Clinic, Monroe	

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°° Except July and August.

(Continued on next page)

List of Officers and Scheduled Meetings of County Medical Societies *(Continued)*

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Green Lake–Waushara	G. G. Mueller Princeton	J. C. Koch Berlin	Last Thursday, every other month starting in Jan.
Iowa	C. L. White Mineral Point	E. J. Hohler Mineral Point	First Thursday following first Monday
Jefferson	E. E. Burzynski 113 N. Third, Watertown	E. P. Schuh 706 Madison, Watertown	Third Thursday°
Juneau	J. H. Vedner Mauston	J. S. Hess Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	W. C. Kleinpell 723 58th, Kenosha	Mr. L. F. Jost, Ex. Sec. Box 669, Kenosha	First Thursday° Elks Club
La Crosse	F. J. Gallagher 630 S. Tenth, La Crosse	J. B. Durst 1707 Main, La Crosse	Third Monday
Lafayette	R. E. Hunter Argyle	N. A. McGreane 123 E. Ann, Darlington	Last Tuesday
Langlade	R. W. Cromer 824½ Fifth, Antigo	J. E. Garritty Antigo	First Monday
Lincoln	F. C. Lane 401 W. Main, Merrill	J. D. Millenbah 121 S. Mill, Merrill	
Manitowoc	J. W. Steckbauer Suite 304, Savings Bank Building, Manitowoc	D. A. Kuljis 1606 Washington Two Rivers	Last Thursday
Marathon	J. V. Flannery 808 Third, Wausau	R. B. Larsen 510½ Third, Wausau	
Marinette–Florence	Clarence H. Boren 1510 Main, Marinette	K. G. Pinegar 516 Houston, Marinette	Third Wednesday St. Joseph's Hospital
Milwaukee	S. A. Morton 3321 N. Maryland Milwaukee	L. R. Schweiger 324 E. Wisconsin Mr. J. O. Kelley, Ex. Sec. 756 N. Milwaukee, Milwaukee	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	H. A. Aageson 1113 Main, Oconto	C. E. Siefert Oconto Falls	
Oneida–Vilas	W. K. Simmons 1020 Kabel, Rhinelander	Marvin Wright 1020 Kabel, Rhinelander	Monthly
Outagamie	George A. Behnke 240 W. Wisconsin, Kaukauna	George A. French 601 W. College, Appleton	Third Thursday° Elks Club
Pierce–St. Croix	P. S. Haskins River Falls	P. H. Gutzler River Falls	Third Tuesday
Polk	Stella I. Burdette Balsam Lake	L. J. Weller Osceola	Third Thursday 7:00 p.m.
Portage	W. C. Sheehan 755 Strongs, Stevens Point	W. A. Gramowski 319½ Main, Stevens Point	
Price–Taylor	W. W. Meyer 410 S. Second, Medford	J. J. Leahy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
Racine	L. M. Lifschutz 816 16th, Racine	W. H. Williamson 1101 Grand, Racine	Third Thursday
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Rusk	M. L. Whalen Bruce	H. F. Pagel Ladysmith	First Tuesday
Sauk	M. F. Huth 203 Fourth, Baraboo	J. J. Rouse Reedsburg	Second Tuesday°
Shawano	L. W. Peterson Shawano	A. J. Sebesta Shawano	Third Tuesday
Sheboygan	J. A. Russell Random Lake	R. M. Senty 1011 N. Eighth, Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	D. S. Sharp 140 E. Main, Mondovi	Robert MacCornack, Jr. MacCornack Clinic, Whitehall	Fourth Tuesday
Vernon	H. E. Oppert 318 S. Main, Viroqua	R. A. Starr Viroqua	Last Wednesday
Walworth	J. B. Schrock Sharon	W. C. Woods 607 Walworth, Delavan	Second Thursday°
Washington–Ozaukee	J. F. Walsh 125 E. Main, Port Washington	V. V. Quandt 57 S. Main, Hartford	Fourth Thursday
Waukesha	James V. Bolger, Jr. 102 E. Main, Waukesha	Philip Wilkinson 618 W. La Belle, Oconomowoc	First Wednesday
Waupaca	Owen Larson Clintonville	H. S. Caskey Clintonville	
Winnebago	P. S. Emrich 456 Mt. Vernon, Oshkosh	G. B. Hildebrand 59 Racine, Menasha	First Thursday
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THE WISCONSIN MEDICAL JOURNAL

Volume 57 SEPTEMBER 1958 Number 9

Multiple Myeloma*

By WILLIAM WEBB, M. D., ROBERT EWER, M. D., and MAURICE HARDGROVE, M. D.
Milwaukee

FORTY-three cases of multiple myeloma have been observed from 1945 to 1955 at the Milwaukee County General Hospital and the Veterans Administration Hospital, Wood, Wisconsin. This report is a review of these cases emphasizing the presenting complaint and the factors which led to the correct diagnosis. Metabolic changes and current treatment of the disease are reviewed.

The ages of the patients varied from 26 to 73 years. The average age was 59 years. In the Milwaukee County Hospital series there were 12 males and 13 females and at the Veterans Hospital all of the 18 patients were males. The total number of males in the combined series was 30.

Symptoms

Skeletal pain was the most frequent presenting complaint. It caused 28 patients (65%) to seek medical attention. The degree varied from mild soreness and aching to excruciating pain. It was not always associated with radiologic evidence of bone destruction. Frequently the pain was confined to the chest cage or spine and was aggravated by movement or external pressure. Deep breathing often intensified the pain when the ribs or sternum were involved. One patient had a transverse fracture of the sternum which caused intense discomfort. Pain in the spine was commonly limited to the lumbosacral area and a constant, dull, boring ache persisted during the night. A preliminary diagnosis of degenerative joint disease, intercostal neuritis, or senile osteoporosis was often made.

Weakness, weight loss, and fatigue were insidious in onset and caused only one-tenth of the patients to seek medical attention. These symptoms were noted for several months before the onset of pain forced the patients to seek medical advice.

One patient's only presenting complaint was a nonpainful, growing mass in the right clavicle. Two were first seen because of persistent nasal hemorrhages and another because of purpura.

Physical Findings

Early physical findings included slight pallor of the skin and mucous membranes and tenderness over some part of the skeleton. Fourteen (32%) patients developed clinically demonstrable fractures during the course of their disease. Palpable tumors of bone were found in only 3 (7%) cases. Paralysis of the lower extremities due to spinal cord compression by myelomatous vertebrae was observed in one case. One patient had purpura of the lower extremities associated with cryoglobulinemia.

The spleen was enlarged in 5 (12%) of the cases. Slight enlargement of the liver was twice as frequent. Associated infections of the respiratory and genitourinary tracts were common.

Laboratory Findings

In 88% of the patients characteristic osteolytic lesions of the bone were demonstrated by x-ray studies. The most common sites of fractures were the ribs, sternum, and vertebrae, although the long bones were occasionally involved. The occasional finding of healed fractures suggested that pathologic fractures were able to unite. Destructive lesions in the skull and pelvis were represented

*From the Department of Internal Medicine, Marquette University School of Medicine and Wood Veterans Administration and Milwaukee County Hospitals, Milwaukee, Wisconsin.

by multiple punched-out, radiolucent areas varying from a few millimeters to three centimeters in diameter. Erosion of the long bones produced a rat-bitten appearance which thinned the cortex and led to pathologic fractures in some cases. General demineralization, osteoporosis, and compression fractures of the vertebrae were noted.

In 96% of the 27 cases in which the serum alkaline phosphatase was obtained it was normal. The plasma globulin was above 3.5 gm.% in 74% of the cases. The number of electrophoretic studies was not sufficient to justify comment on the various protein fractions.

The erythrocyte sedimentation rate was elevated in all cases. Normochromic anemia (hemoglobin less than 12 gm.) was present on admission in 70%. The peripheral blood occasionally assumed a greasy consistency when smeared on the glass slide, and the red cells showed a tendency to rouleau formation. Although there was frequently mild leukopenia, at times secondary infections of the respiratory and urinary tract produced leukocytosis. Plasma cells were found in the peripheral blood smear of one patient. Occasional normoblasts were present.

Bence Jones proteinuria was found in 33%. An initially negative test occasionally became positive later in the course of the disease.

Bone marrow aspiration confirmed the diagnosis in 77%. Repeated aspirations were necessary in 4 cases before myeloma cells were found. No diagnosis could be made from multiple bone marrow examinations in 3 patients. Biopsies of accessible bone lesions were positive for myeloma cells in 4 cases in which bone marrow aspirations were negative.

Diagnosis

The diagnosis of multiple myeloma was ventured after the initial history and physical examination in only 5 patients. It was not suspected until an autopsy was performed on one patient. Osteolytic lesions of bone observed on routine chest x-rays and x-rays of the sites of skeletal pain led to the correct diagnosis in 7 patients. A search for multiple myeloma was made and confirmed after rouleau formation was reported in 6 patients. It was suspected as the cause of obscure anemia in 4 patients and in another one as a cause of purpura.

Eleven patients were studied elsewhere and admitted with the correct diagnosis.

Prognosis

Urethane, ACTH, cortisone, stilbamidine, roentgen ray therapy, and surgery were used with occasional temporary and symptomatic improvement. Eventually narcotics were necessary in most patients.

The average length of life of our patients after diagnosis was established was 12.5 months. The range was 1.5 to 37 months. We know of one other patient who was alive after eight years. He had recurrent and resected myelomatous lesions of the long bones.

All who died had complicating infections of the respiratory or urinary tract, and frequently azotemia was present.[1,2]

Metabolic Anomalies

Bence Jones proteinuria has been reported to be present in over one-half of patients with multiple myeloma. There are reports of it being found in patients having leukemia, polycythemia, metastatic carcinomatous lesions of the bone, bone sarcoma, fibrocystic bone disease, and senile osteoporosis. Large amounts have been found in some patients with myelomatous bone involvement.[3]

Henry Bence Jones wrote in 1848: "On the first of November, 1845, I received from Dr. Watson the following note, with a test tube containing a thick, yellow, semi-solid substance:—'The tube contains urine of very high specific gravity; when boiled it becomes highly opak; on the addition of acid it effervesces, assumes a reddish hue, becomes quite clear, but as it cools, assumes the consistence and appearance which you now see; heat reliquifies it. What is it?' "

Its exact nature has not been determined. It contains traces of methionine and of hydroxyproline. When the sulfosalicylic acid test is negative no Bence Jones protein is found in the urine. It is difficult to separate albumin from the Bence Jones abnormal protein.

An exact method of testing for the protein is as follows: 10 cc. of fresh urine is adjusted to 5.5 pH and heated to 60 C. for ten minutes. A precipitate appears. The urine is centrifuged and decanted. The precipitate is resuspended in 10 cc. of normal urine, to which 10 drops of concentrated nitric acid is added. This suspension is then boiled for ten minutes and filtered while hot. If Bence

Jones protein is present, it will dissolve during boiling and reappear on cooling. This method excludes albumin, proteoses, and pseudo-Bence Jones protein.

The study of Bence Jones protein in the urine and blood has involved chemical, electrophoretic, isotopic, and immunological methods.[4]

Bence Jones proteinuria may be found more commonly in patients having low serum globulin; the relation of these two phenomena is not clear. Has the proteinuria reduced the patients' globulin? Bence Jones protein has a low molecular weight of about 35,000 and thus might filter through the kidney glomerulus. Does the hyperglobulinemia induce the Bence Jones protein molecule to become involved in a complex with high molecular weight serum globulins, and thus prevent the Bence Jones protein from being filtered through the glomerulus? Is the presence of this compound related to a deranged synthesis of serum proteins from amino acids in the body pool? Rapidity of synthesis and excretion of the abnormal urine protein suggests that it is made from metabolites diverted from normal pathways. It is not formed by renal cleavage of unnatural globulins.

Myeloma cells produce a wide range of abnormal proteins which are foreign to the blood and lead to paraproteinemia. Products of disintegrating plasma cells may account for some of the laboratory findings in multiple myeloma. As much as one-third of the nitrogen intake may be lost in the proteinuria and may account for much of the body wasting.

Disturbances in plasma proteins associated with multiple myeloma are of clinical and experimental interest in view of their possible relationship to the metabolism of malignant tissue. Although the abnormal plasma proteins are characteristic, they have no known function.

Bone marrow may show plasmacytosis in many conditions but seldom to the degree found in multiple myeloma. Some degree of plasmacytosis has been found in such varied disorders as cirrhosis of the liver, rheumatoid arthritis, Hodgkin's disease, Boeck's sarcoid, disseminated lupus erythematosus, periarteritis nodosa, fever of undetermined origin, carcinomatosis, mycosis fungoides, giant follicular lymphoma, acquired hemolytic anemia, paroxysmal nocturnal hemoglobinuria, brucellosis, pityriasis rosea, asthma, hay fever, transfusion reactions, sulfadiazine sensitivity, acute infections, lymphogranuloma venereum, kala-azar, schistosomiasis, leprosy, subacute bacterial endocarditis, toxic neutropenia, purpura, and thrombophlebitis. Significant hyperglobulinemia often accompanies the plasmacytosis, but is nonspecific. This is also seen in neoplastic, granulomatous, infectious, and allergic-hypersensitive disorders. Protein antibodies are produced by immature plasma cells and hyperglobulinemia is associated with plasma cell proliferation. In many conditions the hyperglobulinemia is due to an increase in euglobulin and pseudoglobulin I in uniform proportions, but not resembling the disproportions noted in multiple myeloma. In cases of hyperglobulinemia not associated with multiple myeloma, the cephalin flocculation and thymol turbidity may be abnormal.

When rabbits are immunized with horse serum or killed pneumococci, plasma cell proliferation occurs accompanied by a proportional rise in the serum globulin. A similar result has been reported when Schick negative adults receive diptheria toxin causing atypical plasma cells to appear in the bone marrow and peripheral blood. The role of immature plasma cells in antibody formation is established, although the role of the lymphoblast is questionable.

The pronounced hyperproteinemia in multiple myeloma may be due to an increase in any one of the globulin fractions as the result of a perverted mechanism of protein synthesis. Occasionally a patient with multiple myeloma who responds to urethane therapy will show a drop in the abnormal serum globulins or some decrease in Bence Jones urinary protein. An isolated plasmacytoma of the mandible was removed from one patient, which permitted an elevated serum globulin to return to normal. Another patient lost Bence Jones urinary protein after the removal of an involved upper extremity.

The formol-gel test is a simple and fairly reliable method for determining hyperglobulinemia, and is positive when the serum globulin rises above 3.6 gm. %. In this test two drops of 40% formalin are added to 1 cc. of serum, and it is considered to be positive if the serum gels within 24 hours. Often immediate solidification is seen.

Howe's sodium sulfate fractionation method indicates that the abnormal protein belongs to the globulin portion. The normal designated fractions are as follows: 13.5%

sodium sulfate precipitates euglobulin (0.1 to 0.4 gm.%); 17.4% sodium sulfate precipitates pseudoglobulin I, (0.8 to 1.9 gm.%); 21.5% sodium sulfate precipitates pseudoglobulin II, (0.2 to 0.8 gm.%). Albumin (with alpha globulin) remains in the filtrate following precipitation by 21.5% sodium sulfate, (4.7 to 5.2 gm.%).

Kjeldahl technics are used for accurate quantitative determinations of total protein content of the serum and the albumin-globulin ratio.

In multiple myeloma the serum globulin may be well above 8 gm.%, and the albumin-globulin ratio greatly disturbed. Impaired fibrinogen conversion has been found in a single case.

Viscous protein globulins called cryoglobulins precipitate at low temperatures and have been found in the following conditions: chronic rheumatoid arthritis, periarteritis nodosa, subacute bacterial endocarditis, Raynaud's phenomenon, and virus pneumonitis. A few patients with multiple myeloma have had cryoglobulinemia which was accompanied by purpuric skin lesions and hemorrhagic tendencies.[5] A lipoprotein was found to solidify on cooling in one case of multiple myeloma. Amino acid analysis and N-terminal amino acid analysis have been attempted in the study of the myeloma proteins, and appear to show that abnormal forms of serum globulins are synthesized in response to the disease.

The speed with which electrically charged protein particles migrate in a buffer solution under the influence of an electrical current can be determined by paper electrophoresis. Protein particles travel toward the cathode and each protein fraction migrates at a characteristic speed. Albumin moves the fastest.[6,7]

	Normal gm./100 ml.
Albumin	3.65
Alpha I globulin (rich in glyco- and lipoproteins)	0.42
Alpha II globulin (rich in glyco- and mucoproteins)	0.67
Beta globulin (rich in lipids and lipoproteins)	0.91
Gamma globulin	1.53
Total protein	7.14

There is usually an increased amount of globulin and a decreased concentration of albumin in multiple myeloma. The mobility of the abnormal "myeloma" globulin may vary from alpha-II to the post gamma area.

Rarely does myeloma serum contain large amounts of two different abnormal globulin fractions at the same time. When Howe fractionation is normal in suspected cases of multiple myeloma, electrophoretic and ultracentrifugation tests may be added for differentiation.

Despite the high euglobulin or gamma globulin content in multiple myeloma, the bacterial antibody level is reduced. Replacement of a large part of the antibody producing reticuloendothelium by myelomatous tissue may be responsible for decreased resistance to infection.

The Bence Jones urinary protein does not always show the same electrophoretic pattern as the abnormal serum protein. Bence Jones serum protein has not exceeded 0.2 gm.%.

Ultracentrifugation has demonstrated that electrophoretic fractions are quite homogeneous. Urinary Bence Jones protein has a uniform sedimentation rate of 2.8–S to 3.7–S, but the abnormal blood proteins have variable rates. A molecular weight of 150,000—(7S) is indicated for the abnormal serum proteins, whether composed of beta or gamma globulins. Bence Jones urinary protein, however, is of a lower molecular weight (range 24,000 to 90,000).

Paramyloidosis in multiple myeloma was noted in 1872. Myeloma cells appear to manufacture amyloid and are not thought to be phagocytic.[8] Amyloidosis can be produced in rabbits by injecting sodium caseinate which increases serum globulin fourfold. The production of hyperimmune serum in horses causes amyloidosis and hyperglobulinemia. It is said that the myelomatous patient bearing amyloid does not have a large increase in gamma globulin. Why there is a relatively low globulin in the amyloidosis of multiple myeloma is not clear. Some have wondered whether the globulin is changed while producing amyloid in the tissues. The amyloid is not diffusely deposited as in suppuration and does not take up as much congo red dye. The combination of Bence Jones proteinuria and paramyloidosis is common. Bone lesions may be less common in the myelomatous patients who have amyloid deposits. A polysaccharide portion of the serum corresponding to the position of the abnormal globulin has been found, and this substance has an affinity for aqueous crystal violet as does amyloid tissue.

There are three groups of paraproteins in myelomatosis which represent aberrations from normal body proteins. These are the circulating serum paraproteins, urinary, and tissue paraproteins (starch-like paramyloid).

Hypercalcemia and hypercalciuria are common and are associated with demineralization of the bone in multiple myeloma patients. The alkaline phosphatase is generally normal. Ionized calcium has been found to be high in multiple myeloma, and it has been postulated that it combines with the Bence Jones protein to cause protein casts in the renal tubules. In some cases complicated by uremia, renal biopsies have failed to demonstrate the exact case. Uric acid has been found to be high in the blood of some myelomatous patients without obvious renal failure. This has been thought due to increased catabolism of nuclear proteins derived from the nuclei of myeloma cells, similar to that seen in leukemia and polycythemia vera.

Agammaglobulinemia as a syndrome is associated with a susceptibility to infection and absence of plasma cells in the bone marrow.[9] Although the globulin content of the blood may be high in multiple myeloma, the dysgammaglobulinemia may be an explanation for the susceptibility to infection manifested by patients having the disease.[10] The blood cholesterol is frequently low.

Treatment of Multiple Myeloma

Treatment of multiple myeloma is only partially satisfactory. It temporarily influences the disease, but it does not provide a cure. Some of the agents used are interesting in their effects, and appear to be more valuable than the "steel and quinine" used by Doctor Watson and his colleagues during the last century.

Urethane (ethyl carbamate) has been of current interest and in some patients it has temporarily reduced localized pain, retarded growth of myelomatous marrow cells, diminished abnormal serum globulins and Bence Jones proteinuria, changed electrophoretic serum patterns, permitted some repair of bone lesions, reduced fever and malaise, and provided symptomatic improvement.[11]

Urethane is a protoplasmic and mitotic poison which inhibits growth of cells in chronic myelogenous leukemia, but does not have a like effect in acute leukemia. Multiple myelomatosis of a diffuse nature represents a form of aleukemic plasma cell leukemia.

Undesirable side effects of urethane therapy are nausea and vomiting. A suppressive effect on all of the cellular elements of the blood may be noted.

The dosage is from 2 to 4 gm. a day for variable periods (two to three months) depending on the severity of side effects. The hemoglobin, hematocrit, white blood cells, and platelets are evaluated at frequent intervals. If a depression of these values appears, the drug is temporarily discontinued. A relapse following a response to urethane has been hypothesized as being due to the myeloma cells becoming adapted to the drug. Rare incidents of hepatitis have been reported after the administration of urethane. Unfortunately there is no consistent and favorable response to urethane therapy in the majority of cases. The more chronic the disease, the better the result may be.

Roentgen therapy has been used, although the myeloma cells may not be very radiosensitive. It may give some relief of the pain caused by local myelogenous infiltrates. Universal radiation could be used in diffuse, aleukemic plasma cell leukemia. Occasionally, recalcification of bone lesions may be seen after urethane, roentgen, or radioisotope therapy.

Artificial radioactive elements may influence radiosensitive lesions in the same manner as roentgen therapy. Radioactive phosphorus (P^{32}) with a half life of 14½ days has its initial concentration in rapid metabolizing tissue, tumors, bone marrow, and liver, and is subsequently deposited in the bony skeleton.[12] One millicurie intravenously twice a week for a month is usually given. It may be repeated depending on the general clinical picture and the state of the bone marrow. Radioactive iodine (I^{131}) and radioactive iodinated serum albumin have been used. Radioactive strontium has its selective deposition in the bone and behaves similarly to calcium in the body. It may effect normal marrow cells before the abnormal myelomatous cells and has a long half life. Radioactive stilbamidine has not been shown to have a high degree of localization in the pathological cells.

The use of stilbamidine and other diamidines has been intriguing in patients having multiple myeloma. Hyperglobulinemia is present in kala-azar and it is in this condition that these drugs have been used. They precipitate nucleic acid. The myeloma cells

contain large amounts of ribosenucleic acid as shown by basophilic and pyroninophilic staining. A study of the cystoplasm in myeloma cells of a patient who has received these drugs shows that stilbamidine conjugates with ribosenucleic acid. Fifteen daily intravenous injections of stilbamidine in the amount of 100 mg. in 200 cc. of 5% glucose in water have been used, followed by the relief of pain in one-half of the patients so treated. There are some ill effects of these drugs which are discouraging. Phlebitis is common and veins may be promptly occluded. The so-called myelomatous kidney appears to be adversely affected. A dissociated neuropathy of the trigeminal nerve may occur. There may be no loss of the recognition of pain and temperature but touch sensation is affected, and a discomforting paresthesia may develop. These effects may not appear until several months after the injections have been completed, and may last for months or years. The avoidance of sunlight after the drug seems to diminish the occurrence of the neuropathy. Ten per cent of the substance is excreted in the urine, but much of it is retained for several months in the liver, adrenals, and kidneys. Attempts have been made to evaluate the drug in the treatment of trigeminal neuralgia. Pentamidine has been used in the treatment of kala-azar, South American mucocutaneous leishmaniasis, and visceral blastomycosis. Neuropathy and renal damage apparently does not follow its use.

Pentamidine and 2-hydroxystilbamidine have been used in attempts to treat multiple myeloma. No effect has been observed on the hyperglobulinemia or Bence Jones proteinuria. Antimony has been used with some good effect in kala-azar, but it has been found unsatisfactory in the treatment of multiple myeloma. Likewise, nitrogen mustard and triethylene melamine (TEM) have not produced satisfactory results. There is, however, a recent encouraging report on the use of 1 gm. of urethane and 50 mg. of an oral nitrogen mustard compound combined in a daily dose.

ACTH and cortisone have been tried in multiple myeloma with the production of euphoria and some pain relief. A few early cases have shown some clinical improvement as well as a reduction in abnormal serum globulins and marrow myeloma cells. Some associated acquired hemolytic anemias may show improvement following the use of cortical steroids.

Antibiotics may be used for the prevention and treatment of bacterial infections in patients who have multiple myeloma. Transfusions of red cell mass may be given to keep the red blood cell count well above 3,500,000 and the hemoglobin above 11 gm. Nutrition should be well maintained with supplemental vitamins if necessary.

The myeloma plasma cells produce large amounts of myeloma protein which causes an elevation of total serum globulin, and the myeloma band in gamma position may be high. However, this globulin is not active as an antibody and may interfere with normal antibody formation and a susceptibility to bacterial infections appears. Painful and expensive injections of pooled human gamma globulin may be given every three weeks to try to prevent recurrent bacterial infections. One milligram per kilogram of body weight has been recommended as an intramuscular dose.

Surgical removal of isolated solitary lesions is indicated, as in laminectomy when spinal cord or root compressions are present.

Summary

Forty-three cases of multiple myeloma were reviewed. The complaint of skeletal pain in an individual over 40 years of age suggests the possibility of multiple myeloma. In such a patient, the occurrence of anemia, proteinuria, osteolytic lesions of bones, pathological fractures, or rouleau formation in the peripheral blood smear should prompt the physician to employ a bone marrow search for plasma cells. Bence Jones proteinuria and hyperglobulinemia are confirmatory findings.

The combined use of good judgment and proper multiple therapeutic methods may postpone the demise of the patient who has this discouraging disease.

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AMA COUNCIL ON FOODS AND NUTRITION TO HAVE SYMPOSIUM AT MADISON

The fifth annual symposium sponsored by the AMA's Council on Foods and Nutrition will be held October 16 at Madison, Wisconsin. "Factors Involved in Formation and Disease of Bone" will be the subject under discussion at the one-day meeting to be held at the University of Wisconsin. Co-sponsors of the meeting are the University of Wisconsin Medical School, the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin, and the Dane County Medical Society.

A highlight of the program will be a presentation by Willard Libby, Ph. D., of the Atomic Energy Commission, on atomic fall-out and radioactive stronium utilization in the human bone. Other features include: a discussion of "Vitamin D—History and Mode of Action" by Harry S. Steenbock, Ph. D., and Hector F. DeLuca, Ph. D., of the University of Wisconsin biochemistry department; a paper on "Clinical Indications for the Use of Vitamin D Preparations" by David W. Smith, M. D., pediatrics department, University of Wisconsin Medical School; a presentation on "Factors Influencing Tooth Formation and Structure" by W. D. Armstrong, M. D., chairman of department of physiological chemistry, University of Minnesota.

In addition, two panel discussions will be held in the afternoon—(1) "Bone Formation and Repair" under the leadership of D. Murray Angevine, M. D., chairman, department of pathology, University of Wisconsin Medical School, and assisted by L. W. Paul, M. D., chairman, department of radiology, University of Wisconsin; (2) "Lathyrism and Bone Disease" headed by I. V. Ponseti, M. D., associate professor of orthopedic surgery, State University of Iowa, and assisted by F. M. Strong, Ph. D., department of biochemistry, University of Wisconsin, and J. J. Lalich, M. D., department of pathology, University of Wisconsin Medical School.

Further information may be secured from Robert C. Parkin, M. D., University of Wisconsin Medical School, 418 N. Randall Ave., Madison, Wisconsin.

INTERNATIONAL COLLEGE OF SURGEONS POSTGRADUATE COURSE

Another postgraduate course in surgery will be presented by the United States Section of the International College of Surgeons in conjunction with the Cook County Graduate School of Medicine, Chicago, October 13–25.

The course, to be conducted under the supervision of the attending staff of the Cook County Hospital, Chicago, will include illustrated lectures, motion pictures, anatomy demonstrations, operative clinics and practice surgery by the participants on anesthetized dogs.

Consideration will be given to an intensive review of the basic sciences in relation to clinical surgery as well as to surgical technique, surgical complications and management of the surgical patient. In addition to 20 hours of surgical anatomy on the cadaver, the program will include lectures and demonstrations on the following:

Gastric surgery, physiology, use of blood and derivatives, pediatric surgery, surgery of large bowel, surgery of small bowel, intestinal obstruction, anorectal surgery, surgery of pancreas and spleen, gallbladder surgery, thoracic emergencies, cardiac arrest, hand injuries and infections, gynecologic surgery, surgery of hernia, abdominal injuries, surgery of the esophagus, and thyroid surgery.

Additional information may be obtained from the International College of Surgeons, 1516 Lake Shore Drive, Chicago 10, or Cook County Graduate School of Medicine, 707 South Wood Street, Chicago 12.

A TECHNIQUE FOR EVALUATING THE EFFECTS OF HEART-VALVE SURGERY WHILE AN OPERATION IS IN PROGRESS

A technique for evaluating the effects of heart-valve surgery while an operation is in progress has been developed by a team of surgeons and cardiologists at the Public Health Service's National Heart Institute in Bethesda, Maryland.

With this technique, direct measurements are made of the heart's output of blood and of differences in pressure on each side of abnormally narrowed, or "stenosed," valve openings just before and after these openings are surgically enlarged.

The new technique allows a more precise and immediate evaluation of the results of heart valve surgery than has previously been possible with conventional techniques, by which pressures and output of blood are measured before and after an operation but not during it.

By making these measurements while an operation is going on, the new technique tends to eliminate the influence of all variables except the critical one—the size of the valve opening. It gives the surgeon a better idea of how much of the valve's function has been restored and lets him know whether to enlarge the valve opening still further during the same operation.

The new method is applicable in operations for stenosis of any of the four valves of the heart. Its value was demonstrated in studies of twenty-four patients undergoing valve surgery at the Heart Institute (18 with mitral, four with aortic, and one each with pulmonic and tricuspid valve stenosis).

The new technique was developed by Drs. Herbert Tanenbaum, Eugene Braunwald, and Andrew Morrow of the Heart Institute Clinic of Surgery.

After exposing the heart to view, the Heart Institute team measures pressures simultaneously in the chambers immediately upstream and downstream from the diseased valve by puncturing these chambers with fine (20-gauge) hypodermic needles. The needles are attached directly to two hand-held pressure transducers, which change the pressure pulses coming through the needles into electrical pulsations.

The pulsations from both transducers are projected as two parallel tracings moving across the screen of a cathode ray oscilloscope. The difference between these synchronized pressure tracings reflects the pressure difference, or "gradient," across the diseased valve.

The effect of the surgery in relieving the abnormal pressure gradient is apparent when these measurements are repeated immediately after the surgeon opens the heart and inserts his finger (or an instrument) into the valve opening to enlarge it.

To determine the heart's output of blood just before and after this valve manipulation, the Heart Institute team injects measured amounts of a special blue dye directly into either the pulmonary artery or the left atrium, which carry the blood from the lungs to the left ventricle to be pumped to all body tissues.

As it circulates through the heart and out into the arteries, the dye-containing blood is drawn at a constant rate from an arm artery through a densitometer (a photoelectric device that detects the dye concentration). The concentration of the dye and its transit time through the circulation are also projected visually as a "dye dilution curve." The characteristics of this curving line indicate the output of blood from the heart.

Stenosis of heart valve openings is a common form of heart disease which may be inborn. More often, however, it is due to repeated episodes of rheumatic fever. This disease attacks the delicate mobile "leaflets" or "lips" of the valve, which normally close together tightly and open widely at each heartbeat to regulate flow in and out of the chambers.

The adhesive inflammations of rheumatic fever may progressively fuse the lips together. This narrows the opening against the passage of blood, creating abnormal pressure gradients between the adjacent chambers, and overworking the heart.

The operation most commonly used to free these stenosed valve components and relieve the abnormal pressure gradients is called "commissurotomy," for the commissures or lines where the lips of the valves come together.

In the past, accurate evaluation of the results of commissurotomy has been dependent on measuring pressure gradients through a flexible plastic catheter tube threaded into the heart from outside the body during the periods before and after the operation. During these comparatively lengthy and eventful intervening periods, factors other than surgery on the valve—such as variations in the patient's medical therapy, stress and rest experiences—can alter the pressure and flow patterns within the heart and thus mar the precision of the evaluation data.

Note: The new diagnostic technique is described in technical detail in the *New England Journal of Medicine* for March 13, 1958.

Operative Levin Tube Enterotomy in Acute Bowel Obstruction

An Aid in Exposure

By JOHN T. SULLIVAN, JR., M. D., Sc. M.*
Milwaukee

PRACTICALLY all abdominal surgery would be simple to perform if operative exposure ceased to be a problem. Operations that have been classed as "simple" or "performed with ease" never present difficult problems of exposure. Good exposure requires the easy accessibility of all structures within the operative field. The technical problem of resecting or suturing, in itself, requires little effort on the part of the operator. Difficulties in exposure may be caused by the following:

1. *Intricate anatomical structures.* This occurs in many regions where the anatomy is complicated and hidden by normal structures. These exist even in the ideal patient with maximum surgical exposure. Examples are: (a) the head of the pancreas and its relationship with the superior mesentery vessels, (b) the relation of the right ureter, posterior duodenum, and the pelvis of the right kidney. Such structures, even in cadaver dissection present problems of exposure and visualization due essentially to the nature of their anatomy.

2. *Difficulty of exposure due to individual factors in a specific patient.* Visualization of simple structures can be relatively difficult and inadequate in a very obese patient with dense adhesions from previous peritonitis or with intraperitoneal hemorrhage.

3. *Poor exposure due to deficient surgical technique.* This can occur when incisions are improper, the retraction inadequate, or the understanding of the surgical anatomy is poor. These are the direct fault of the operator. Thus, exposure of the gallbladder area might be poor even in a thin patient having no intraabdominal pathologic entities other than cholelithiasis. In such a patient, cholecystectomy probably would be classed as "very difficult" if the incision was too small or improperly placed, the retraction haphazard, the surgical assistants untrained, or fundamental knowledge of the gross regional anatomy lacking.

This third factor can be prevented and corrected by proper surgical technique. The second factor, although inherent to the individual patient, may be greatly aided by specific maneuvers and painstaking technique. It is with this thought in mind that the use of a long tube enterotomy in bowel obstruction to increase exposure and simplify correction of the pathologic condition, is described.

A major task confronts the surgeon when he has a patient with an advanced or neglected case of bowel obstruction, especially if the patient is debilitated or obese. Fortunately today, with prompt surgical intervention the patient with advanced bowel obstruction and massive distention is not frequently encountered.

Upon opening the peritoneum in an individual with advanced bowel distention, the

The article by John T. Sullivan, Jr., M.D., on "Operative Levin Tube Enterotomy in Acute Bowel Obstruction" in this issue of *The Wisconsin Medical Journal* describes a very intriguing way of decompressing, at the operating table, distended loops of bowel. There are times in any operation when knowing one additional maneuver such as this might facilitate the handling of the case tremendously. As the author states in his paper, he is not recommending it as a routine procedure, but if carefully performed at an opportune time, it may prove very valuable. I would strongly recommend that anyone who has to handle these cases would do well to read this article.

—Editorial Director

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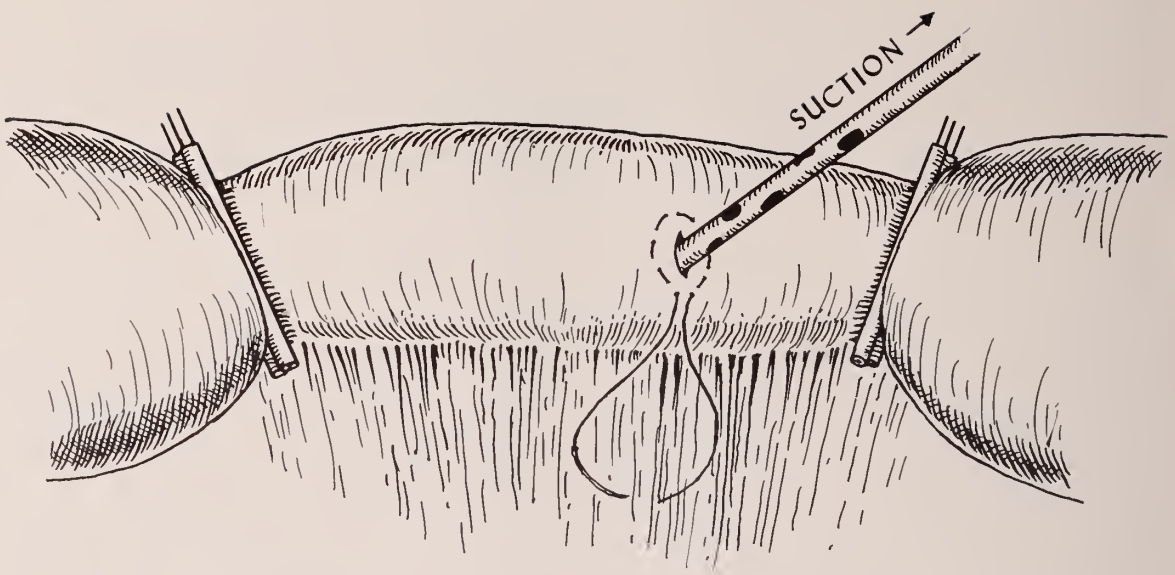

Fig. 1—A short section of distended bowel has been "stripped" or "milked" and rubber-shod intestinal clamps positioned. A catgut purse-string suture is inserted on the antimesenteric border and a small stab-wound is made. A sterile Levin tube with additional holes about its distal end is inserted and the purse-string suture is tightened but not tied.

immediate problem is one of exposure and localization of the obstructing factor. Evisceration of dilated loops of bowel along with serosanguineous peritoneal fluid makes exposure and identification of structures a major problem, especially if xyphoidpubic incisions are to be avoided. It is well known that rough handling of thin bowel enhances postoperative adhesions and increases the risk of inadvertent perforation of one or more bowel loops. Needless time may be lost and undue trauma inflicted in a haphazard and frustrating search for the obstructive site. Even when accepted techniques are followed the constrictive point may not be readily located. *In such a situation,* suction enterotomy may so collapse distended bowel as to make corrective procedures relatively simple.

Technique

Suction enterotomy is best performed at the distal or proximal end of the dilated small bowel. This is facilitated by the identification of the ligament of Treitz or the ileocecal region. After either of these areas has been identified and isolated, preferably outside the abdomen, the eviscerated distended bowel loops should be covered with warm, moist saline packs and the area selected walled off with additional packs. On the bowel area selected, some form of gentle, soft, occluding clamps should be positioned. This can be provided by use of the assistant's fingers or with soft, rubber-shod, intestinal clamps. A seromuscular, purse-string suture of 2–0 chromic catgut on an atraumatic needle is then inserted in the antimesenteric wall so as to include an area approximately one-half inch in diameter. If the area be too thin and tense, local aspiration by means of an 18-gage needle on a syringe should be performed before inserting sutures or opening the bowel. After the loosely-inserted suture has been placed, a small stab-wound is made through the bowel wall within the diameter of the purse-string suture. Suction is essential at this point, although with the intestinal clamps previously placed there is little leakage of fecal material. Trocars and glass suction tubes have been utilized for aspiration but an ideal method is the use of a sterile, large caliber Levin tube. Additional openings are made along the distal 10 cm. of this tube and the point inserted into the stab-wound. (Fig. 1) This is continued proximally or distally depending on the area selected. Extreme gentleness while aspirating both gas and liquid bowel contents is necessary at this stage of the procedure. Bowel loops are best handled with moist saline packs while guiding and threading the Levin tube, which is done similar to threading a curtain on a rod. (Fig. 2) The suction apparatus should be observed carefully to prevent overflow. The container must occasionally be emptied before the procedure has been completed. When

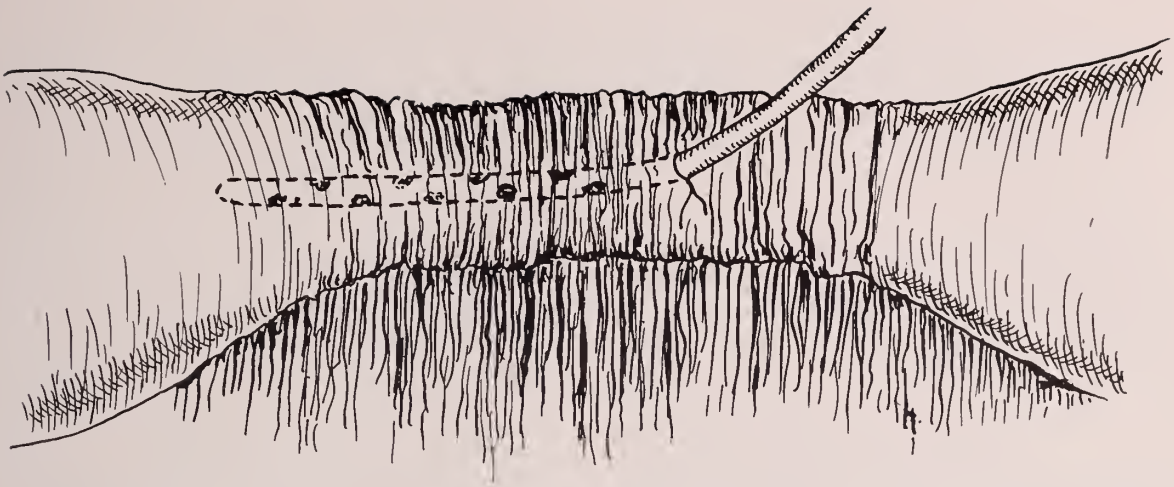

Fig. 2—The intestinal clamps are removed and the distended bowel is threaded onto the Levin tube similar to threading a curtain on a rod. The removal of intestinal gas and liquid by means of suction attached to the Levin tube will result in collapsed bowel with a thicker and more vascular wall and increased exposure within the abdominal cavity.

the distended loops of bowel proximal to the obstruction have been collapsed, the obstructive site can usually be visualized and isolated. The collapsed loops of bowel are best returned to the peritoneal cavity and retracted, utilizing warm saline packs. The Levin tube is then gently withdrawn from the enterotomy opening and the purse-string suture tied. Immediately following this maneuver, interrupted serosal sutures of fine silk are inserted transversely over the purse-string area. These may be either of the Lembert or Cushing type. When closure is performed on a collapsed and empty bowel, risk of leakage from the area is minimal providing the bowel obstruction is eliminated. This may range from simple severance of adhesive bands to resection of gangrenous areas of bowel with reanastomosis. Any procedure performed with adequate exposure and the absence of dilated loops of bowel will be done with greater ease and allow for closure of the abdominal incision without undue tension. This latter factor will also reduce the risk of postoperative wound evisceration.

Discussion

Some surgeons condemn the above procedure because of fear of opening into an unprepared and distended bowel containing extremely virulent toxic contents and in a seriously sick patient. These facts cannot be denied but may be reduced to their relative importance by the following considerations:

1. With careful technique and adequate "walling off" of the enterotomy site, little or no spillage of bowel contents need be anticipated.

2. Increase in "exposure" and shortening of operating time for correction of the obstruction is obtained by emptying and collapsing the proximal distended bowel. This often restores circulation and allows a more accurate evaluation of bowel viability.

3. Suction enterotomy will also shorten the period of postoperative ileus and reduce the risk of evisceration, the latter by facilitating easy and adequate closure of the abdominal incision.

4. "Blow-out" of the enterotomy site is not to be expected if the primary bowel obstruction has been corrected.

5. Past experience of many surgeons has proved the safety of this technique.

Summary

1. Adequate exposure is a major factor in good surgical technique.

2. Severe bowel obstruction may present a difficult problem of exposure and location of the obstructive site because of multiple, distended, and thin-walled bowel loops.

3. A technique of Levin tube suction enterotomy is outlined.

4. Factors in favor of this simple procedure are presented.

2040 West Wisconsin Avenue.

SECOND ANNUAL MEETING OF AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS

The second annual meeting of the American Association of Medical Assistants will be held at the Palmer House, Chicago, Illinois, on October 31, November 1 and 2. All medical assistants are welcome to attend. Physicians are asked to call this meeting to the attention of their assistants.

Three Wisconsin people will be on the program at the Saturday, November 1, session. A Wisconsin medical assistant will speak on "Asoptic Techniques". Harold Scherer, business manager of the Monroe Clinic, Monroe, Wisconsin, will give a talk, "Go and Do Likewise"; and Robert J. Samp, M.D., director of the tumor clinic, University Hospitals, Madison, Wisconsin, will be the master of ceremonies at the banquet Saturday evening.

Hotel reservations should be made directly with the Palmer House in Chicago. Registration fee is $18. Check should be made payable to the American Association of Medical Assistants and forwarded to Mrs. Mary S. Aird, 1749 West 9th Street, Chicago 43, Illinois.

EXAMINATIONS OF THE AMERICAN BOARD OF INTERNAL MEDICINE

Oral examinations of candidates in the Midwest for the American Board of Internal Medicine are set for April 15–18, 1959, at Chicago, Illinois. Closing date for acceptance of applications is January 1, 1959.

PREPARATION OF MANUSCRIPTS FOR THE WISCONSIN MEDICAL JOURNAL

Exclusive Publication: Articles are accepted for publication on condition that they are contributed solely to this Journal. Publication elsewhere will be subsequently authorized in the discretion of the Medical Editor.

Correspondence: Address all correspondence relating to publication of scientific papers to the Medical Editor, Box 1109, Madison 1, Wisconsin.

Manuscript: Type double spaced, on 20 pound white paper, 8½ by 11 with one inch margins at the top, bottom, and right, and 1½ inches on the left. Submit the original and two carbon copies. Use the metric system throughout. Call drugs by their generic names. The trade names can be added, in parenthesis, if they are considered important. Keep one copy of the paper.

Identification: Place the name of author and page number at the upper left-hand corner of each page except the first.

Footnotes and References: Use the style of the *Quarterly Cumulative Index Medicus* published by the American Medical Association, which requires, in the order given: name of author, title of article, name of periodical, with volume, pages, month—day of month if weekly—and year as follows:

4. Doe, J. E.: What I know about it,
Wis. Med. J. 54:717–719 (Dec.) 1954.

And, include only those references specifically referred to in the text.

Reprints: An order slip for reprints with a table covering cost will be sent with the page proof to each contributor.

Illustrations: Four illustrations per article are allowed without cost to the author. Beyond this number the author must pay the actual cost of illustrations. Place the name of the author on the back of each illustration, table, etc. Submit clear and distinct 3 by 5 glossy photographs. Make drawings in black ink on white paper. Attach a slip of paper to the bottom of the illustration with the author's name, identification of article, and appropriate legend. Photographs and drawings will be returned if so requested.

Under ordinary circumstances articles are scheduled about six months in advance. The approximate date of publication, subject to change, will be given the contributor when the article has been accepted.

Society members throughout the state are encouraged to write up their interesting cases and submit them for publication. The editorial staff welcomes the opportunity of helping you prepare your article for the printer.

Prevention of Back Injuries in Industry

By DAVID J. ANSFIELD, M. D.
Milwaukee

INJURIES to the back in industry are extremely common and are usually very costly. Loss in wages, loss in production, increased cost of insurance premiums, and ultimately an increase in the cost of the manufactured product result from accidental injuries to the back. Many of these back injuries are preventable; yet insufficient attention has been focused on the prevention of industrial back injuries. By and large, the majority of injuries to the back occur in people doing strenuous work, particularly in those who handle materials. Workers whose jobs require heavy lifting, pulling, and pushing are more apt to develop back injuries in the course of their work than individuals in other jobs.

In order to prevent injuries to the back in industrial workers, it would be wise to focus our attention on this large group of individuals doing strenuous work.

Pre-employment Examinations and Proper Placement of Employees at Work

Perhaps the most important single factor in reducing the incidence of back injuries in industry is the use of pre-employment examinations for applicants seeking jobs which require strenuous physical exertion. Nowhere is it more essential to screen applicants than in heavy industry, where strenuous physical exertion on the part of the employee is routine. To successfully make proper placements of applicants for strenuous jobs and to eliminate those unfit for this work, it would be wise for those responsible for the proper selection and placement of these individuals to observe the following criteria:

1. Avoid placing at a strenuous job an individual who has had no previous experience at heavy work. These people are usually soft and flabby and are, therefore, more vulnerable to back injuries. Because they lack experience at heavy work, such work becomes a hazard; and they are, therefore, more likely to develop a back injury than those who are experienced at strenuous work. People who have had previous experience at strenuous work, but who have been away from such work for some time should not suddenly be placed at work requiring heavy lifting, since they may have become soft and may have lost some of the muscle tonus which they had when they were doing strenuous work. These people should be eased into strenuous jobs gradually.

2. Avoid placing at strenuous work an individual who is appreciably overweight and flabby and who has poor posture. These people usually have poor muscle tonus and often coordinate poorly. Their flabby musculature does not stand up well under excessive strain, thus throwing an added burden onto the ligamentous structures of the back. People who are overweight and have obese and protuberant abdomens usually are already in an excessive lumbar lordosis and often are in the extreme of hyperextension before strain is applied to the back. Thus, when they attempt to perform some heavy lift, they readily sprain the ligaments in the lower back. Obesity and poor posture in an individual increase the vulnerability of that person's back to injury when strain is applied to the back. Furthermore, once these people injure their backs they are considerably more difficult to cure than a person who is of average weight and whose posture is not faulty.

3. Avoid placing at heavy work, particularly jobs requiring heavy lifting, people who are underweight and slight of build. These people sometimes are called upon to lift weights equal to their own body weight. Such lifting is excessive for their body build.

4. Avoid placing at strenuous work individuals who have just recovered from a prolonged illness or serious injury. People who have recovered from a heart attack or tuberculosis or some other chronic ailment which has disabled them for weeks or months should not be expected to resume strenuous work immediately upon their return to work. Similarly, people who have had serious injuries which have disabled them for long periods of time should not, upon returning to work be expected to resume immediately their former occupation if such work is heavy. These individuals who have recovered

from a protracted illness or injury have become weakened and have lost a good deal of muscle tonus. They are flabby, and their musculature and ligamentous structures cannot tolerate at once the strain which some heavy jobs demand.

5. Avoid placing at strenuous work individuals who have had frequent recurrent attacks of back trouble in the past. These individuals either do not know how to coordinate well when doing strenuous work or they have structurally weak backs which will not tolerate excessive strain. They probably would do well at light work, but when they are assigned to strenuous work their backs give out and painful and disabling symptoms often result.

6. Avoid placing at strenuous work individuals who are already suffering from a permanent back disability. These individuals are already handicapped before assuming any strenuous undertaking. Their backs are not able to stand up under the strain which a normal back can tolerate. A breakdown of their backs may be expected when excessive strain is applied to them. Once these already disabled backs break down, rehabilitation is often difficult and prolonged. These people, therefore, are not suited for strenuous work.

7. Avoid placing at strenuous work people who have chronic spondylitis, spinal curvature, congenital structural weaknesses of the back, or degenerative disk disease. These people have backs which will not tolerate a great deal of strain; and if their backs are subjected to excessive strain, disability will follow promptly. Pathological conditions of the back are often not discernible on ordinary clinical examination, and frequently only by x-ray examination of the back can these abnormal conditions of the spine be discovered. *It is, therefore, extremely important and necessary that individuals who are to be placed at strenuous work be subjected to x-ray studies of their spines in order to eliminate any person whose back shows these abnormalities.* While x-rays of the back are costly, they will often save considerable money for the employer by eliminating individuals who are unsuited for physically strenuous jobs, so that in the long run the cost of x-ray taking will be considerably cheaper than the cost involved in selecting employees who are unsuited for such work. X-rays of the spine need not be taken for all types of occupations, but in individuals whose jobs call for strenuous work, particularly in heavy lifting, x-rays of the spine should be a primary requisite before such applicants are placed in that type of work.

8. Avoid placing at strenuous work individuals who are too old to handle heavy work. Elderly people whose muscles are no longer supple and whose coordination and reaction time is slow will injure their backs easily if subjected to excessive strain. These people are unsuited for heavy work, and once they injure their backs it is difficult to rehabilitate them. There are many workers who grow old on the job; and, while they were able to tolerate strenuous work in their younger days, after a number of years they find they can no longer continue at the same heavy job they had been doing for years. Employers should recognize this and relieve them of such arduous work when their general physical condition and their age require a change to less strenuous work. This is often overlooked. I have seen people who had been doing strenuous work for many years and who ultimately arrived at an age and physical condition where they should no longer be doing such strenuous work. Employers should from time to time review the type of work their older employees are doing and should reclassify them in relation to age and physical condition.

If the above criteria are observed and adhered to, many injuries to the back in industry would be prevented.

Prevention of Injuries to Employees While at Work

Once an employee has been assigned to strenuous work, care must be taken that he does not injure his back at work. Apart from the fact that various safety rules should be observed and enforced by the plant regarding the physical layout at work, which methods this paper will not concern itself with, the employee himself should observe certain safety rules.

Avoidance of Excessive Lifting. Unless he is especially trained in weight lifting, the average worker will often injure his back if he makes an excessive lift. Just how much weight would be considered excessive will vary with the individual and the sex. In general, however, it would not be unreasonable to assume that a lift in excess of 100 pounds would be excessive for the average individual; and while there are some workers who

habitually lift this amount of weight in their daily work without developing back trouble, numerous other workers would and actually do injure their backs when lifting this amount of weight. While it is possible to injure a back with a lift of less than 100 pounds, it is not unreasonable to state that all things being equal the heavier the lift the more likely is the person to injure his back; and, conversely, the lighter the lift the less one is likely to develop a back injury.

In determining how much of a lift would be excessive, one would have to take into consideration the experience that the worker has had in doing lifting. A person who is not accustomed to lifting is more apt to injure his back than one who has been lifting for years and knows how to lift. A person's age is another criterion in determining how much weight he can safely lift. Obviously a man of 70 would not be expected to be capable of lifting a weight equal to what a man of 30 could lift, all other things being equal. Body build is another factor that must be considered in determining how much weight an individual can safely lift. A person who is muscular and has good muscle tonus, who is well coordinated, and who has good posture should be able to lift more weight without injury than an individual who is flabby and obese, who coordinates poorly, and who has poor posture. Thus, what might be an excessive lift for one individual might not be for another, and all these factors must be taken into consideration. Women are not expected to be capable of lifting weights as heavy as men. In general, I would feel that a female worker should be capable of lifting safely about half of what a male worker is capable of lifting. An individual slight of build would, all other things being equal, not be expected to lift as much as an individual who is well built.

Proper Training of Employees for Performing Strenuous Work. Proper training of employees for performing strenuous work is an important factor in the prevention of back injuries. Many employees are assigned to strenuous work, such as heavy lifting and strenuous pulling and pushing, without having had any special training in such work. The inexperienced worker will frequently injure his back when he attempts to lift heavy objects because he is unfamiliar with the safe and proper manner of lifting.

1. The correct manner of weight lifting should be taught every worker whose job requires strenuous lifting. The proper positioning of the worker in relationship to the object to be lifted, pushed, or pulled is essential in prevention of injury to the back. Employees should be instructed regarding the various safety movements when doing this type of work, such as flexion of the knees, tensing the buttock muscles, and pulling in the abdomen when bending over to lift.

2. They should be instructed to lift in a straight-forward position and should avoid whenever possible lifting with the trunk in a twisted position. Lifting with the trunk in a straight position is less apt to produce injury to the back than if the trunk is in a twisted attitude.

3. Avoidance of lifting objects that one has to reach out for is also important in prevention of injury to the back since the closer the object to be lifted is to the body the less leverage falls onto the back structures; and, therefore, less force is applied to the back.

4. Lifting with the body in a constrained position is also harmful and should be avoided if injury to the back is to be prevented.

5. Hurried, unpremeditated, and unplanned strenuous lifts will often lead to back injury. On the other hand, careful, well coordinated strenuous physical effort can usually be accomplished without physical harm.

6. Proper footing when lifting, pulling, and pushing is essential in preventing injury to the back. Many injuries to the back occur by a sudden slip of the foot while in the process of lifting only because the footing was not secure before the lift, the push, or the pull was undertaken.

7. Avoidance of chilling of the back is important in the prevention of back pain. Workers frequently become perspired in the course of their work; and if the back is chilled suddenly through exposure to a draft, the muscles will go into spasm, and the back will become stiff and painful when the worker begins to bend and lift. This cause for back pain is far more common than is generally realized.

Conclusion

Back injuries in industry are extremely common and are very costly. Many back in-

juries are preventable by proper screening of applicants through thorough pre-employment examinations and by proper placement of these individuals at various jobs. Observance of various safety measures by the employer and especially by the employee himself will often help in preventing back injuries.

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208 East Wisconsin Avenue.

NEW POSTGRADUATE PROGRAM AT UNIVERSITY OF WISCONSIN MEDICAL SCHOOL

The University of Wisconsin Medical School is strengthening and expanding its programs in postgraduate medical education in an effort to work more closely with physicians in the state, it was announced recently by John Z. Bowers, M. D., Dean of the Medical School, and Robert C. Parkin, M. D., Assistant to the Dean.

The new program will be supported in part by the W. K. Kellogg Foundation. Five courses will be presented in 1958–1959 with the titles and dates as follows:

1. "Advances in Anesthesia and Resuscitation"—October 10, 11, 1958.
2. "General Practice—1958"—November 6, 7, 8, 1958.
3. "Hematology and Hypertension"—March 19, 20, 21, 1959.
4. "Problems of the Newborn Period"—April 2, 3, 4, 1959.
5. "The Pathology and Radiology of the Skeletal System"—May 21, 22, 23, 1959.

For the convenience of registrants, the postgraduate office will make room or motel reservations. Transportation and meals will also be arranged. Wherever possible the courses have been scheduled in connection with athletic and social events and tickets will be available for the Wisconsin–Purdue football game. Tickets to the Wisconsin–Northwestern football game will be available in connection with the course in General Practice.

To assist interested physicians in planning, the programs are being developed well in advance of the courses and registration for any of the five courses may be made at any time.

The programs will feature distinguished guest speakers and more frequent panel and discussion sessions. Doctor Bowers and Doctor Parkin hope the "new look" in postgraduate medical education at the University will be found attractive and useful by physicians in the state.

* * *

The program for the first postgraduate course, "Recent Advances in Anesthesia and Resuscitation," to be held Friday and Saturday, October 10 and 11, 1958, is as follows:

FRIDAY, OCTOBER 10—

8:00 A.M. Registration, Room 426, University Hospitals.
8:45 A.M. Orientation, by Dr. Robert C. Parkin, Assistant to Dean, Medical School.
9:00 A.M. *Newer Ethers*, by Dr. O. S. Orth, Professor and Chairman, Department of Anesthesiology.
9:20 A.M. *Fluothane and Chloroform*, by Dr. B. J. Bamforth, Associate Professor of Anesthesiology.
10:00 A.M. *Recent Intravenous Agents*, by Dr. John F. Tench, Instructor in Anesthesiology.
10:45 A.M. *Lidocaine—Regional Usage*, by Dr. John E. Steinhaus, Associate Professor of Anesthesiology and Department Chairman of Emory University Medical School, Atlanta, Georgia.
11:15 A.M. *Urea—Its Intravenous Administration*, by Dr. Manucher Javid, Associate Professor of Neurosurgery.
12:30 P.M. Luncheon, Hospital Cafeteria.
1:30 P.M. *Induced Hypotension—Theory, Methods, Drugs*, by Doctor Orth.
2:15 P.M. *Hypothermia—Theory, Techniques, Equipment*, by Doctor Bamforth.
3:15 P.M. *Improvements in Anesthesia Machines*, by Dr. Karl L. Siebecker, Associate Professor of Anesthesiology.
3:45 P.M. *Improvements in Anesthesia Techniques*, by Doctor Tench.
4:15 P.M. Question and Answer Session, Panel by all speakers.

SATURDAY, OCTOBER 11—**Advances in Circulatory and Respiratory Resuscitation.**

8:30 A.M. *Principles and Methods*, by Dr. William P. Young, Associate Professor of Surgery.
9:00 A.M. *Equipment—Defibrillator, Pacemaker, etc.*, by Dr. Richard Botham, Instructor in Surgery.
9:30 A.M. *Chemical Reversal of Ventricular Fibrillation*, by Doctor Steinhaus.
10:15 A.M. *Advances in Respiratory Resuscitation with Movie;* Courtesy Dr. Peter Safar, Baltimore City Hospital, by Doctor Siebecker.
11:15 A.M. Question and Answer Session, Panel by all speakers.

Analysis of 200 Cases of Carcinoma of the Prostate Treated Conservatively

By ERBY J. SATTER, M. D.,* and J. B. WEAR, M. D.**
Madison

IN 1941 Charles Huggins, *et al.*, published a series of three articles[1,2,3] on the effect of castration and diethylstilbestrol on carcinoma of the prostate. Since that date, this form of treatment has become an acceptable form of conservative therapy.

In 1951 Nesbit and Baum[4] analyzed 1,818 cases of carcinoma of the prostate treated with and without castration and diethylstilbestrol. Their cases, however, were only followed for a 60-month period. They concluded that the best form of treatment was orchiectomy plus stilbestrol. This was followed in order by orchiectomy, and lastly by stilbestrol alone which added very little longevity over no treatment at all.

The final analysis of any treatment can only be properly evaluated in a closed series (all patients having expired). For this purpose we have studied the first 100 cases of carcinoma of the prostate that were treated at University Hospitals with orchiectomy and stilbestrol. These patients were treated in the years 1941, 1942, and 1943, and are now all deceased. For a controlled series, 100 cases of carcinoma of the prostate were also analyzed from 1937 to 1939; these patients did not receive the benefit of orchiectomy and estrogen therapy. In all cases the tissue diagnosis was established by transurethral resection. None of the cases of either series was treated by radical surgery or other means.

In the untreated series of cases (Group I), the youngest patient was 47 years old, the oldest 87 years old. The average mean age of the group was 67.3 years. In the treated series (Group II), the youngest patient was 48 years old, the oldest 86 years old. The average mean age of this group was 69.9 years old.

Table 1 indicates the relative number of patients in each series from the fourth to the ninth decade of life. The average life span of the untreated group was 22 months following the date of diagnosis. The longest survivor lived nine years from the age of 77 to 86. In the treated group, the average life span was 56 months. Eight patients lived 10 years or longer; the longest survivor lived 15 years from 56 to 71. The longevity according to decade of life in both groups is listed in Table 1.***

It can be readily seen in the untreated group that the patients in the 70-to-79-year bracket had the longest survival time. The

From the Department of Surgery, Section Urology, University Hospitals, Madison, Wisconsin.
* Resident in Urology, University Hospitals.
** Chief Urologist, University Hospitals.

*** According to Metropolitan Life Insurance Company statistics, the average life expectancy of a 65-year-old male is 12 years. At 75 years, the average expected longevity is six years.[5]

TABLE 1

UNTREATED (GROUP I)			TREATED (GROUP II)		
Age	Number of Patients	Average Longevity in Months	Age	Number of Patients	Average Longevity in Months
40–49	1	36	40–49	1	30
50–59	11	18	50–59	14	57
60–69	37	19	60–69	36	60
70–79	42	26	70–79	36	55
80–89	9	17	80–89	13	49
	100	22		100	56

Untreated group received transurethral resection of prostate only. Treated group had bilateral orchiectomy and 5 to 15 mg. diethylstilbestrol daily in addition to transurethral resection.

other decades were relatively equal. In the treated group the best results were seen in the 60-to-69-year group. It is statistically significant that the treated group in the eighth decade of life outlived the control series 32 months per patient. For overall comparison of all types of treatment (excluding radiation) see Table 2.

TABLE 2—COMPARATIVE RESULTS

Type of Therapy	5-Year Survival	10-Year Survival
No Treatment	10 per cent	0 per cent
Orchiectomy and Stilbestrol all stages	40 per cent	8 per cent
Radical Perineal all stages [6]	43 per cent	21 per cent
Orchiectomy and Stilbestrol stage I [7]	53 per cent	22 per cent
Radical Perineal stage I [6]	68 per cent	43 per cent
Normal Life Expectancy age 67 [5]	80 per cent	50 per cent

Discussion

Cancer of the prostate can be treated in many ways. Various approaches include calculated neglect, stilbestrol with or without orchiectomy, transurethral resection, radical prostatectomy, and radiation therapy with or without surgery. Because of the wide range of possibilities, we feel re-evaluation of a conservative approach is in order.

Almost all urologists agree on a choice of treatment of an early prostatic carcinoma in an otherwise healthy male 45 to 60 years of age. This type of case deserves a radical prostatectomy.

Over the age of 70, a radical procedure can hardly be justified in view of the satisfactory response to conservative management alone. On our patients treated conservatively, we are doing an orchiectomy and starting stilbestrol, 5 mg., t.i.d., at the time of diagnosis. Cortisone is held in reserve for terminal management. It is our belief that this approach offers the patient greater longevity, more comfortably, than calculated delay in hormonal management. The disagreement as to the best method of treatment occurs in the 60-to-70-age group. Flocks'[8] early reports on the use of radioactive gold are somewhat disappointing. The final results of the radical approach in the sixth decade, when considering its inherent morbidity and mortality, began to approach the results of conservative management.

Each case must be carefully individualized after a complete evaluation. The patient must be given a full share in making this final decision.

Conclusions

1. A series of 100 cases of carcinoma of the prostate treated with orchiectomy and stilbestrol has been compared to a control series of 100 cases of this disease without the benefit of this therapy.
2. The average mean age of the untreated group was 67.3 years, the treated group 69.9 years.
3. The longest survivor in the untreated group lived nine years; the longest survivor in the treated group lived 15 years.
4. The average life span of the untreated group was 22 months following the establishment of the diagnosis; the longevity of the treated group was 56 months following the date of diagnosis.
5. Longevity was best in the 70-to-79-year-old patients in the control series, being on the average 26 months following the date of diagnosis. The longevity of the treated group was best in the 60-to-69-year period, being 60 months following the date of treatment.
6. It is significant that the 80-to-89-year-old group lived 32 months longer in the treated group than in the untreated group, indicating that age is no contraindication to the institution of orchiectomy and stilbestrol for treatment of carcinoma of the prostate.
7. Eight per cent of the treated cases lived 10 years or longer.
8. Treated patients 70 to 75 years old are living half of their normal expected life span. Patients 75 to 85 years old are obtaining 75 per cent of their normally expected longevity.
9. The sum total of added years of adult life of the treated group over the untreated group totaled 283 years.

(E. J. S.) 1300 University Avenue.

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FAMILY RESPONSIBILITY FOR HEALTH AND MEDICAL CARE IS IMPROVING IN MADISON

Ten years of operation of a program based on developing individual responsibility of the family for its own health and medical care is succeeding in Madison, Wisconsin, according to figures reported on payment of 14 x 17 chest X-rays for period 1955 to 1957, inclusive. All too many of us in the field of Public Health have taken the easy and popular road of offering more and more direct service, more and more free or part-pay clinics for various procedures, avoiding the thorny problem of getting families to spend money on medical and dental care when needed rather than on luxuries and conveniences.

For several years the Madison City Health Department has urged people to elect for themselves the most appropriate of three pay plans when a physician recommended a 14 x 17 chest film. Surprising and encouraging results are seen from the following tabulation:

SUMMARY OF METHOD OF FINANCING 14 x 17 X-RAYS AS FOLLOW-UP OF 70 MM. PROGRAM 1955–1957—MADISON, WISCONSIN

Total recommended for 14 x 17 X-ray	1022	
Total moved before seen re-follow-up	25	
	997	
Total seen by physician who said 14 x 17 not needed	24	
	973	
Facilities used for 14 x 17 X-ray		
Private payment—own physician	589	(72%)
$3.00 Special rates	191	(19%)
(3 of these at Lakeview in 1955—9 in 1956)		
Paid for by TB Association	38	(4.2%)
	818	
Other:		
Student Health	23	
Veterans Administration Hospital	14	
Hospital Employee	5	
River Pines Sanatorium	1	
Mendota State Hospital	4	
Truax	6	
By Insurance	1	
By Relief Department	1	
	55	

Summary: A study of three years' experience in giving patients free choice of any one of three plans reveals that in this city most individuals, 72%, chose the private full-pay plan. Alternates offered were reduced rate of $3.00 by courtesy of local hospitals and radiologists, and completely free (the special rate paid by Tuberculosis Association).—CHARLES K. KINCAID, M. D., *Health Commissioner*

AROUND-THE-WORLD REFRESHER CLINIC TOUR

The International College of Surgeons will hold its fourth Around-the-World Postgraduate Clinic and Lecture Tour, beginning with departure from San Francisco on October 10. The return to New York will be on December 3.

Further information may be had by writing to Dr. Arnold S. Jackson, tour coordinator, 16 South Henry Street, Madison 3, Wis., or to the International Travel Service, Inc., 119 South State Street, Chicago 3, Ill.

THE TUBERCULOUS PATIENT AND WISCONSIN LAWS

Meeting the needs of the tuberculous patient under Wisconsin laws was the subject presented at the sixth in a series of Wisconsin Anti-Tuberculosis Association Fifteenth Anniversary Events on Thursday, June 26, at Wauwatosa Memorial Center.

A brief resume of legislation by Attorney General Stewart G. Honeck pointed out Wisconsin's interest in the tuberculous.

In 1905, the Wisconsin State Sanatorium was established (closed in 1957). Later, county sanatoriums were authorized. Other highlights mentioned included the Free Care Law passed in 1945, which provides free sanatorium care for any tuberculous patient with legal settlement in Wisconsin, or with, an aggregate of five years residence. If the patient has disability benefits, workmen's compensation, or insurance which could be applied to care in a TB sanatorium, this is the only payment secured. Then, in 1955 the cost of routine chest surgery was determined to be a part of the patient's sanatorium treatment, and therefore, the sanatorium included this in the patient's Free Care. In 1955, counties were permitted to establish a county hospital in a portion of the county sanatorium which operates within the appropriate regulations.

Dr. Milton Feig, Madison, Director of Preventable Diseases, State Board of Health, discussed the various methods that a patient can utilize for admission to a sanatorium. (1) A patient may be admitted on a private pay basis if he desires. In this event, he is charged the per capita cost of the institution. (2) The patient may be admitted through the Free Care Law. In this instance, a court order must be obtained. Ordinarily, the patient requests the judge to authorize admittance. In some instances the judge will commit a patient who will not enter a sanatorium voluntarily and is not following public health precautions. There are other methods of admission used occasionally. He stressed that the sanatoriums in Wisconsin provide excellent medical care for the tuberculous.

Off the cuff, he presented his own opinions on present needs of the State Board of Health regarding the tuberculous. (1) Most sanatoriums are too small to require a full time social worker. Yet, this type of personnel is badly needed. He felt that the services of medical social workers to handle the social and welfare needs of the patient could be carried out through district health offices. Thus, one worker could service several sanatoriums. (2) Wisconsin should subsidize or aid the sanatoriums in order to help them employ an occupational therapist to direct leisure time activities and help with early rehabilitation planning. (3) Better means of referral to the Rehabilitation Division of the State Board of Vocational and Adult Education is needed. (4) The State Board of Health should be allowed to provide drugs free of charge for the tuberculous patients treated by physicians outside of the sanatorium. Dr. Feig said he did not recommend treatment by a physician outside a sanatorium as a substitute for early sanatorium care. But, he believes, that a patient in whom the disease is in a noncommunicable state and who is getting adequate treatment and follow-up from his own doctor should not be forced into a sanatorium. This, he felt, would contribute to better tuberculosis control. (5) More funds are needed for case finding. One-third of the cases of suspected tuberculosis are lost because of inadequate follow-up.

Miss Gertrude Mulaney, R.N., Superintendent of Nurses, Milwaukee Health Department, said that the Public Health Nurse represents the official health agency under state and municipal statutes in direct care of tuberculous patients. The nurse has many duties; some of which are case finding, interpretation of the Free Care Law, control of contacts, arrangement for sanatorium care, instruction in personal hygiene, encourages health examinations, and assists in mass surveys.

Mrs. Mary Quinn, Medical Social Worker, Pinehurst Sanatorium, challenged the audience to do the right thing at the right time for the individual and his needs. The skills of many people are needed. This team work is most effective when we learn to work together. As we use each other's services, it is possible to ascertain where we have failed and where we have succeeded, and thus realign our thinking. She also commented that tuberculosis is a symptom of life problems, and we must seek physical health to live well and effectively. County sanatoriums are the focal points for tuberculosis control work. We raise many questions on how this job can be done. If the following questions can be answered, we will effectively meet our goals. (1) What are the needs of the patients we service? (2) How can these needs best be met? (3) How can these needs best be financed? (4) Who can best do the job?

Mr. John A. Kubiak, Chief of the Rehabilitation Division, State Board of Vocational and Adult Education, stated that the aim of the state rehabilitation program is to return the disabled person to employment.

In 1957, 749 tuberculous clients were served by the state rehabilitation program. The types of services given to these clients were: counseling, testing, training, maintenance, artificial appliances, medical treatment, dental treatment, glasses, psychiatric treatment, training supplies, occupational tools and equipment, and transportation.

Mr. Leo T. Jelinske, Director, Shawano County Department of Public Welfare, stated that the laws of public welfare and public assistance affect the patient and his family.

Every county with a population of less than 500,000 must have a Department of Public Welfare to carry out various responsibilities.

Psychiatric Aspects of Menopause

By HENRY VEIT, M. D., F. A. P. A.*

Milwaukee

MUCH has been written about menopause—perhaps too much! For that very reason, a terse, concise, psychophysiologic approach appears necessary to better understand the menopause period for the individual woman. After all, the management of the postmenopausal woman is not only a matter of understanding her physical ailments, but also her emotional background as well. The menopause consists not only of an interruption of menstrual periods, the periodic hot flushes and sweating episodes, and changes in the endocrine system, but also of emotional reactions that have to be viewed as psychologic adaptive devices.

Donovan[1] is of the opinion that it is unlikely that any woman experiences the menopause without some type of reaction. This reaction may be so mild that there is no awareness whatsoever; or it may be a repetition, a maintenance, or an exaggeration of psychologic adaptive devices that are necessary for that individual. Where marginal adjustments have been made to the daily living situations, the menopause may heighten the difficulties to such an extent as to bring the patient into the category of classifications such as psychotic, psychoneurotic, or psychophysiologic autonomic and visceral disorder responses. Clinically, one tends to see that a patient with a schizoid personality now has definite schizophrenic reactions; paranoid personality, paranoid reactions; and obsessive-compulsive personality disorders, involutional psychotic reactions. Where somatic reactions have been necessary to express tension in a mild way, the patient now has to be labeled under the psychophysiologic disorders; for example, skin, musculoskeletal, cardiorespiratory, lymphatic, and gastrointestinal reactions. Some of the milder psychoneurotic reactions become more severe and then first come to the attention of the family doctor or the psychiatrist. The personality disorder group cannot be disregarded because at this transitional phase of living—the menopause—more difficulties can occur as a result of the restructuralization of total family living. Hence, with more deviant behavior symptomatology, less acceptance of that individual as a problem will occur. This emphasizes that psychiatric reactions of nonhormonal origin may all too frequently coincide with the menopause.

Case Reports

Case 1—This is a case of an obsessive-compulsive personality in whom a neurotic depressive reaction occurred at menopause. The patient was a 53-year-old married nurse who, having to face readjustment at the menopause, was unable to do so and developed a neurotic depressive reaction. With the husband's retirement and with no children in the home, new adaptations became necessary in everyday living. Sickness and death among relatives and friends precipitated the overwhelming anxiety that had been kept in check for years by obsessive-compulsive defenses. Much unconscious hostility had accumulated which brought about hypertension and eventually brought about further internalization of the hostility to cause the severe depression. Hospitalization with electrostimulation became necessary for a two-week period of time. This technique was utilized instead of electroshock therapy in order to avoid the possibility of memory disturbance, which is not too well tolerated in obsessive-compulsive personalities. With follow-up psychotherapy her status much improved. More adequate reorganization at the obsessive-compulsive personality level again followed and no psychotherapy has been necessary for the past year.

Case 2—This is a patient with a personality trait disturbance, passive dependency type, who at the menopause had to release accumulated emotional tension in a physiologic manifestation; namely, a duodenal ulcer. She was referred for psychotherapy in the hope that the acute ulcer difficulties could be alleviated and surgery avoided. It was believed that ventilation of her internal conflicts—satisfying a need for dependency,

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supportively and temporarily, and helping her make more limited adaptations in herself and her environment—would be helpful. As the psychotherapeutic interviews progressed it was noted that she had a very stormy, disturbed childhood and adolescent life, typified by a poor relationship with her parents, conflicts over sex and religion, and an inability to assert herself and demand her rights as an individual person. Inferiority feelings, inadequacy feelings, self-depreciation, feelings of worthlessness—all of these mediated towards making her feel grateful for even slight attention. Idealistic and sensitive, she was unable to accept and set up limitations, unable to receive emotionally and maturely from others, and unable to ventilate accumulated hostilities. Alone, even in marriage, she finds it still necessary to react to her husband as an understanding, extremely permissive mother. Her ulcer and somatizations of her emotional tensions are used periodically to get attention and to control her husband.

On her last visit to her internist, she was told that x-ray examination indicated that she was "real healthy." This upset her considerably because she has a need to cling to the somatic expressions of the emotional tensions. The threat of surgery no longer exists. Now, feeling able to live with her symptoms, she terminated psychotherapy stressing that there are three things she must learn to do: (1) "I must set definite limitations and make everyone including myself live up to them." (2) "I must learn to receive, that is I must learn to take help from others in the like amount as I give. You cannot take money out of the bank without putting money back into the bank." (3) "I must learn to let out all hostility. I must learn to let out steam in one way or another. This could be accomplished by the creative urges in me."

Case 3—This case is typical of an involutional psychotic reaction. The patient was a 41-year-old white married woman who was seen in consultation May 4, 1955. An orderly personality, somewhat immature, hysteroid, anxious and tense, she had apparently been able to make a marginal adjustment for many years. However, the severe psychiatric disorder was able to break through her defenses as a result of an accident in which she fractured an ankle—the disability acting as the precipitating factor. Inactivity, withdrawal, and isolation from friends, permitted her to develop fears of cancer and fears of separation from her growing daughter and son. Undue preoccupation and worry over the past and future tended to bring about insomnia, guilt, anxiety, agitation, depression, and paranoid trends. The symptoms culminated in a suicidal attempt necessitating urgent psychiatric care.

With electroshock therapy, psychotherapy, and ataractic drug therapy, the patient improved and has been able to make a satisfactory adjustment at home. However, supportive psychotherapy has constantly been necessary during the past two years and may continue to be necessary for some time, as her sickness seems to follow a protracted, prolonged course.

Discussion

At the menopause, the involutional psychotic reaction[2] stands out as worthy of special interest. It is a reaction that occurs with a characteristic depression at menopause though the patient has no previous history of manic-depressive reaction, and it is found in the obsessive-compulsive personality types. It tends to have a prolonged course and is manifested by worry, intractible insomnia, guilt, anxiety, agitation, delusional ideas, and somatic concerns. In some cases the predominant symptom is depression; in others there are paranoid features. Often somatic preoccupations occur to a delusional degree.

Karliner[3] has written of other psychiatric reactions that should also be understood. The manic-depressive patients often have an episode at the menopause, as they have a very low threshold for tolerance of physical, mental, or emotional stress. Neurotic defense mechanisms appearing for the first time at menopause may be an expression of an underlying organic disease. This may include such conditions as brain tumor, pernicious anemia, and blood dyscrasias. Insofar as the sexual role of the individual is concerned, one must be fully aware of the fact that sexual libido and orgastic ability are not hormonal but an emotional function.

Generally one should take into consideration the psychologic functioning of the woman prior to menopause. The magnitude of psychological trauma and the success of the adaptive devices used by the woman depend upon the circumstances of her past and current life. Women able to accept and sat-

isfy normal feminine drives with emotionally rewarding relationships in a state of relative emotional security are little threatened by psychologic losses related to menopause. The ever-frustrated women appear to experience a greater sense of loss for that which they have never satisfied. Women who have been able to adapt marginally to life's problems by means of pathologic psychiatric devices tend to repeat, exaggerate, or maintain these adaptive devices during the menopause.

Helen Deutsch, M.D., in her book entitled, *The Psychology of Women*, emphasizes a phase that she terms "a thrust of activity" at or near menopause. This thrust of activity refers to increased activity involving either the threatened area or misplaced social, artistic, or intellectual pursuits. Hence, it is not uncommon for a woman whose children are grown and married to derive compensatory satisfactions in obtaining a college degree during and following her menopausal period. Other women take pleasure in social welfare activities; some express their energy drive in club work.

From the foregoing comments one must get the impression that hormone therapy of the "disturbed woman" at menopause is not enough, One may grant, according to Ingvarsson,[4] for some there is improvement from hormone therapy due to inhibition by estrone via the hypothesis of certain products of the suprarenal cortex. Still, as Dr. J. C. Weed[5] of the Ochsner Clinic points out, the treatment must be directed toward alleviation of the physical suffering and reassurance and supportive therapy, rather than haphazard hormone administration.

5836 W. Lisbon Avenue.

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2. The Committee on Nomenclature and Statistics of the American Psychiatric Association, American Psychiatric Association, Mental Hospital Service, Diagnostic and Statistical Manual, pp. 1–130, 1952.
3. Karliner, W.: Psychiatric aspects of menopause, Am. Pract. & Digest Treat. 4:256–259 (Apr.) 1953.
4. Ingvarsson, O.: Hormone treated cases of menopausal psychoses, Digest Neuro. & Psych. 20:31 (Jan.) 1952.
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AMERICAN RHINOLOGIC SOCIETY ANNUAL MEETING OCTOBER 17–18

The American Rhinologic Society will hold its fourth annual meeting in the Palmer House, Chicago, October 17–18.

Among the topics to be discussed will be pulmonary and nasal physiology, laboratory and clinical aspects of bone transplants, hump removal, roof repair, and nasal process corrections.

The Society will display many reprints, papers, slides, charts and other teaching and study material available to the profession upon request. Two new exhibits suitable for showing at state society and other professional meetings will also be presented.

The profession is cordially invited to attend as guests. There will be no registration fee.

For further information, write to Dr. Robert M. Hansen, secretary of the society, 1735 North Wheeler Avenue, Portland 17, Oregon.

POSTGRADUATE COURSES ON DISEASES OF THE CHEST

The Council on Postgraduate Medical Education of the American College of Chest Physicians will present the following postgraduate courses this fall:

CLINICAL CARDIOPULMONARY PHYSIOLOGY, Edgewater Beach Hotel, Chicago, Illinois, October 13–17, 1958.

DISEASES OF THE CHEST, Park–Sheraton Hotel, New York City, November 10–14, 1958.

Tuition for each course is $100.

Further information may be obtained by writing to the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

FOURTH ANNUAL FALL CANCER SYMPOSIUM AT UNIVERSITY OF WISCONSIN

The Wisconsin Medical Alumni Association will hold its annual fall get-together (Wisconsin's Cancer-Football Scrimmage) in conjunction with the Fall Cancer Symposium at the University of Wisconsin Medical Center on Saturday, October 11, Madison. The symposium is co-sponsored by the Wisconsin Division of the American Cancer Society and the Cancer Research Section of University Hospitals.

Over 250 physicians from, in and around Wisconsin are expected to participate. Invitations are being extended to physicians practicing in Wisconsin and to Wisconsin Medical Alumni throughout the United States.

Registration will begin at 8:30 Saturday morning, October 11. From 9:00 to 11:00 a.m., clinical and laboratory cancer papers will be delivered and rendered.

A special feature at 11:00 a.m., will be a lecture by Dr. Richard H. Overholt, an eminent chest surgeon who is clinical professor of surgery and chief of surgery at New England Deaconess, Boston Tufts Medical College. His topic will be "The Direct Approach to Shadow and Substance in Lung Cancer."

There will be a noon luncheon at the hospital cafeteria for physicians and their wives. The football game features Wisconsin against Purdue. Tickets at cost will be available to those attending.

MEDICAL CONTINUATION COURSES AT UNIVERSITY OF MINNESOTA

Medical continuation courses to be presented at the Center For Continuation Study, University of Minnesota, are as follows:

September 23–25: Pediatrics for Pediatricians.
October 6–8: Obstetrics for Specialists.
October 23–25: Dermatology for General Physicians.
November 3–8: Pediatric Radiology for Radiologists.
November 17–19: Fractures for General Physicians.
November 17–22: Neurology and Neurosurgery for General Physicians.
November 20–22: Physical Medicine for Specialists.

For further information concerning the above courses, write to the Director, Department of Continuation Medical Education, 1342 Mayo Memorial, University of Minnesota, Minneapolis 14, Minnesota.

ANNOUNCEMENT FROM RED CROSS

A recent announcement by the Dane County Chapter of the American Red Cross states that Wisconsin physicians in 33 Wisconsin counties depended wholly on Red Cross supplies of blood for one out of every ten patients they attended last year. This totaled 47,060 pints of whole blood requested by 79 Wisconsin hospitals during 1957. In addition, the Red Cross supplied the Wisconsin State Board of Health for free distribution a total of 36,300 cc. of gamma globulin; and 48 units of fibrinogen; 1,005 units of 100 cc. vials of serum albumin were supplied on request directly by Red Cross to these Wisconsin hospitals. New uses of blood fractions are now being developed.

The Dane County Chapter still receives requests from Wisconsin physicians for plasma. However, the Chapter no longer distributes plasma from the Badger Regional Center, but it does distribute the fractions for which plasma was once useful.

MICHIGAN SMS ANNUAL SESSION SEPTEMBER 30–OCTOBER 3

The Michigan State Medical Society's 93rd Annual Meeting will start Tuesday, September 30, at the Sheraton–Cadillac Hotel in Detroit, Michigan, and continue through October 3. Thirty-six guest lecturers from the nation's leading medical centers will participate in the scientific program which includes six assemblies and 15 section meetings during the four days of intensive postgraduate study.

Clinicopathologic Conference

Sponsored by the Section on Pathology, State Medical Society of Wisconsin
Guest Editor: Marvin D. Blackburn, Jr., M. D.

CASE PRESENTATION *

Dr. C. W. Crawford: The patient was a 42-year-old white female who was admitted to the hospital for the first time on May 5, 1958, for observation and treatment of severe anemia. Her symptoms were extreme weakness associated with epigastric distress which began approximately ten days prior to admission. The patient stated that for the past two years she had been ingesting a considerable amount of a proprietary antacid for the relief of epigastric distress.

She was well developed and well nourished but appeared extremely pale, quite weak and listless. The abdomen was somewhat protuberant and slightly tender in the epigastric region. The pelvic organs and rectum were not abnormal.

On admission the sedimentation rate was 18 mm. in one hour, the hemoglobin 6.7 gm., and the white blood cell count 6,950. She had 57% polymorphonuclear leukocytes, 1% eosinophils, 1% basophils, 40% lymphocytes, and 1% monocytes. The hematocrit was 19%. Examination of the feces for occult blood was negative.

Dr. Lyle H. Edelblute: An upper gastrointestinal x-ray examination performed on May 5, 1958, demonstrated the presence of a duodenal ulcer near the apex of the bulb on the lesser curvature aspect. The ulcer crater was small but rather deep with radiation of the mucosal folds. In addition there was in the stomach a filling defect along the lesser curvature of the pars media which appeared to be adherent to the lesser curvature. Its shape was not constant, however, and its size was variable depending upon how much pressure was placed upon it with the pressure cone. No evidence of a pedicle was seen. In view of the presence of a coexisting duodenal ulcer it was believed quite possible that the variable filling defect seen along the lesser curvature of the stomach could well be a blood clot. The possibility of a mural mass could not be excluded, however, and a re-examination was suggested. An examination of the lower gastrointestinal tract on this date showed no abnormalities.

The stomach was re-examined on May 14, 1958. An attempt was made on this examination to perform a combination air and barium contrast study with the use of a carbonated beverage. Unfortunately there was prompt duodenal filling and the lesser curvature of the stomach was obscured by the transverse portion of the duodenum. In spite of this a filling defect again was seen. It appeared considerably smaller than on the previous examination of May 5, 1958. Again no evidence of pedicle was visible nor was there radiation of the mucosal folds toward the site of the defect. Because the results of the examination were not considered conclusive the patient was rescheduled for an oil contrast study on May 20, 1958.

A repeat examination using a double contrast of barium suspension and mineral oil was performed on May 20, 1958. The mucosal mass was again seen. It appeared perfectly smooth. No crater formation associated with this finding was visible at any time during any of the three examinations. On the basis of the examination it was concluded that this was not an artifact but a mucosal mass. On this final examination the duodenal bulb was seen to have healed completely and showed no evidence of ulcer except for a slight prominence of the mucosal folds in the area where the ulcer crater was previously seen.

Doctor Crawford: The patient was placed on a strict medical regimen for peptic ulcer and was given 1,500 cc. of whole blood. At the time of discharge on May 15, 1958, it was reported that the hemoglobin had risen to 13.2 gm.% and the hematocrit to 40%. This striking rise from the low level on admission is worthy of note in its own right. Except for the agreement between the hemoglobin and the hematocrit in each case some technical error would be suspected. At the time of discharge she was placed on propantheline (15 mg. four times daily), an antacid as needed, and instructed to return in one week

* From Bellin Memorial Hospital, Green Bay.

for further x-ray studies. At this time she was much improved.

Discussion

Doctor Crawford: This case is of interest for several reasons, mainly because of the coexisting lesions. The patient did not consider the epigastric distress during the past two years significant enough to seek medical attention. Not until the extreme weakness and melena were noted did she become concerned. The patient was admitted to the hospital with the initial diagnosis of upper gastrointestinal bleeding. However, the bleeding that had lowered the hemoglobin to 6.7 gm. had apparently stopped by the time of admission because fecal specimens were negative for occult blood. After an active duodenal ulcer crater was discovered by x-ray, the patient was placed on a strict medical regimen and within a short period of time was asymptomatic. Repeated x-ray examinations, however, demonstrated a persistent lesser curvature lesion. Even though the patient was asymptomatic, exploration was indicated to determine the nature of this lesion.

Dr. R. G. Wochos: This 42-year-old woman presented a past history of a duodenal peptic ulcer and an apparent recent history of gastrointestinal bleeding. Routine ulcer management and blood replacement had resulted in subjective improvement and correction of her secondary anemia. Three serial upper gastrointestinal x-ray studies revealed apparent healing of the duodenal ulcer; but, as noted, a constant filling defect of the antral lesser curvature persisted. This had the radiological appearance of an intramural gastric tumor, possibly a lymphosarcoma, a leiomyoma, or a leiomyosarcoma. A large gastric polyp was also considered. The gastrointestinal bleeding might have had as its source either the duodenal ulcer or the gastric lesion. It was felt that surgical exploration was indicated because of the presence of the gastric lesion which might be either benign or malignant. It was also assumed that a history of gastrointestinal hemorrhage from one of the above sources was a further indication for probable gastric resection.

Doctor Crawford: On May 26, 1958, the patient was readmitted for evaluation of the gastric lesion. She had been asymptomatic since her previous admission and had remained on a strict ulcer regimen.

Fig. 1—Appearance of the unopened stomach.

The patient did not appear acutely ill and had no evidence of pallor. Her pulse rate was 80 per minute and the blood pressure was 120/80. The abdomen at this time was not abnormal.

At the time of this admission the patient's hemoglobin was 12.2 gm.%, the hematocrit 37%; and the white blood cell count 8,600 with 60% polymorphonuclear leukocytes, 1% basophils, and 39% lymphocytes.

Doctor Wochos: I saw this patient in consultation. She gave a history of vague, intermittent epigastric and right upper quadrant pain for the past several years. There had been no significant nausea or vomiting at any time. She did not particularly relate the discomfort to meals, although at times it seemed that the discomfort had been most marked after eating. It was relieved on some occasions by antacid medications. Approximately three weeks previously she had been hospitalized after the rather gradual development of weakness and fatigue. At that

time she had noted tarry stools present for a week or more. Her hemoglobin then was about 8 gm. X-rays at that time revealed a duodenal ulcer and a filling defect of the lesser curvature of the antrum of the stomach. This filling defect was noted on two subsequent x-ray examinations, although the duodenal ulcer healed under conservative therapy. Blood transfusions, three in number, were given and the patient's hemoglobin returned to a normal level. She was well during the next two weeks.

She had minimal tenderness in right upper quadrant. No abnormal abdominal masses were felt. It was my impression she had a duodenal ulcer, healed, with previous history of bleeding and possibly an intramural tumor of antrum of stomach; either a gastric polyp or lymphosarcoma of stomach. I recommended exploration and gastric resection if indicated.

On May 27, 1958, an exploratory laparotomy was performed. The only significant abdominal pathology was a 3 x 6 cm. mass along the lesser curvature of the stomach continuing into the gastrohepatic ligament and extending apparently into the stomach itself. It had the appearance of an intramural gastric tumor. The liver was clear of disease and the pelvis normal. There was some thickening at the region of the gastric pylorus, but no actual evidence of a duodenal ulcer could be demonstrated. Because of the location of the lesion and the lack of evidence of metastases, a gastric resection was accomplished in a subtotal manner by the Hofmeister–Polya method. A short loop of jejunum was brought upward through the transverse mesocolon and a postcolic anastomosis was accomplished in two layers. The patient tolerated the procedure well and received 500 cc. of whole blood during the operation.

Dr. Marvin D. Blackburn, Jr.: The resected portion of stomach contained a fleshy leiomyoma which was sharply circumscribed and which contained uniform smooth muscle cells. It measured 4.5 x 3.0 cm. and the overlying mucosa was not ulcerated. (The gross appearance is illustrated in figs. 1, 2 and 3; the histologic appearance in fig. 4.)

Doctor Crawford: The patient made an uneventful recovery with only the usual postoperative complaints of "gas pains", inability to have bowel movements, and only minimal pain. She was discharged on June 7, 1958, without complaint.

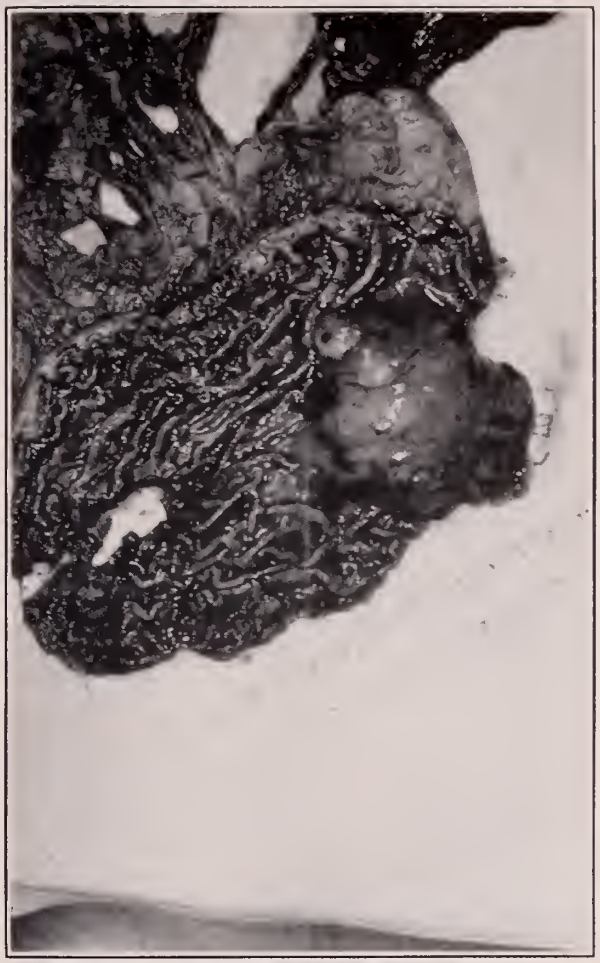

Fig. 2—Stomach opened showing position and size of the lesion.

Doctor Edelblute: This case has several perplexing x-ray aspects, at least two of which are worthy of discussion.

The first of these is that the mass varied in both shape and size over the three examinations. The change in shape is not so remarkable since a variation in the amount of pressure used can change the shape of even a polyp; the change in size is not easy to explain. In each of the three examinations the size of the defect varied from 2 to 4 cm. This is not the expected appearance of a mural mass. Except for its presence over three examinations the initial impression that it was an artifact such as an adherent blood clot would have been maintained.

The second interesting feature about this finding is that at no time did it show a mucosal defect which could be an ulcer crater. Since the patient was admitted with a diagnosis of massive upper gastrointestinal hemorrhage, the lesser curvature gastric

Fig. 3—Lesion incised.

Fig. 4—Histologic appearance of the lesion (about 450X).

finding could scarcely be blamed for it. If it should be determined to be an organic finding one wonders how long it would have remained undiscovered if the duodenal bleeding had not occurred.

The final conclusion was that it was a nonulcerating mural mass, the type of which could not be definitely identified.

Doctor Wochos: At the time of surgery we were confronted with a rather large intramural gastric tumor in the suspected location. There was no evidence of a duodenal ulcer at this time, although the region of the pylorus appeared thickened and slightly scarred.

A subtotal gastric resection with removal of approximately two-thirds of the stomach, including the omentum, was accomplished. Since the pathological diagnosis is leiomyoma with no evidence of malignancy, the prognosis is, of course, very good. Even with a lymphosarcoma or a leiomyosarcoma, however, the prognosis following adequate resection would probably be better than if the lesion had been a gastric carcinoma.

Doctor Crawford: It would be of interest to know just how long the leiomyoma had been present. Characteristically this type of tumor produces symptoms only when the tumor ulcerates, bleeds, obstructs the outlet of the stomach, or becomes so large as to be noticeable to the patient. There may be no symptoms, and if epigastric distress is present, it is usually not severe. Perhaps in this patient the tumor could have contributed to the epigastric distress she had experienced for the past two years. There is no doubt, however, that the duodenal ulcer was responsible for the bleeding. Had the patient not had this episode of bleeding, she might have gone on for several months or years without having had a diagnosis made and definite treatment accomplished.

Comments on Treatment

Editors—F. E. SHIDEMAN, M. D., University of Wisconsin, Madison
HARRY BECKMAN, M. D., Marquette University, Milwaukee

Use of Thyroid Hormones

Considerable progress has been made in the past few years in the study of normal and abnormal thyroid physiology. Some of this investigation has led to the development of new compounds possessing thyromimetic activity. For example, the discovery by Gross and Pitt–Rivers in 1951 of 3:5:3-triiodothyronine in human plasma was quickly followed by its successful clinical application in the treatment of hypothyroidism. Similarly, the discovery that tetraiodothyroacetic acid and triiodothyroactic acid are the metabolic products of thyroxine and triiodothyronine respectively has led to experimental trials of these substances in patients with thyroid deficiency. Meanwhile, synthetic thyroxine and desiccated thyroid continue to be available to the physician. The selection of a drug for the patient needing thyroid hormone has become more complicated than formerly when the physician's choice was limited to desiccated thyroid.

In the vast majority of patients needing thyroid replacement therapy desiccated thyroid (U.S.P.) provides very satisfactory results. It is readily available, reasonably uniform in potency, effective, and inexpensive. The latter is an important consideration when medication has to be continued for many years. The attainment of maximum therapeutic effect is slow, approximately 7 days, and upon withdrawal the basal metabolic rate falls gradually over a period of several weeks to the pretreatment level. Thus, a very smooth, steady metabolic effect that is advantageous can be achieved with desiccated thyroid. The usual dose required to maintain an athyreotic adult in a state of euthyroidism is from 2 to 3 grains (120–180 mg.) daily. Therapy in the myxedematous patient must be initiated cautiously, especially in the older individual, in order to avoid precipitation of myocardial ischemia. For this purpose treatment should be started with ¼ grain (15 mg.) daily for 7 to 10 days, then raised to ½ grain (30 gm.) for another 10 days, with additional increments of ½ grain at intervals of 10 days to 2 weeks until a maintenance dose is reached. As a general rule, the older the patient and the longer the duration of myxedema the more cautious one's therapy should be. The development of anginal pain is a danger signal indicating that the older patient's tolerance for thyroid has been exceeded.

Occasionally, the physician may prefer to use the sodium salt of l-thyroxine, although it offers no practical advantage over desiccated thyroid for routine use. It offers no qualitative effect not obtained with desiccated thyroid, the rate of response is no different, and it is somewhat more expensive. The usual dose of thyroxine needed to maintain euthyroidism is in the range of 0.1 to 0.2 mg. daily.

Triiodothyronine, being a relatively new thyroid hormone, has received considerable attention. It possesses important properties which significantly modify its clinical effect as compared to either thyroxine or desiccated thyroid. Experimental evidence indicates that it is not firmly bound to serum globulin and is not well retained within the intravascular compartment, in contrast to thyroxine. It rapidly enters the tissues in relatively high concentration and exerts its metabolic effect. It is therefore not surprising that the significant difference between thyroxine and triiodothyronine lies in the speed with which the metabolic response occurs. With triiodothyronine a clinical effect on basal metabolic rate is observed within 4 to 6 hours after administration, with a maximal response occurring in 48 hours. Further, following cessation of treatment with triiodothyronine the basal metabolic rate returns to pretreatment levels in from 7 to 9 days. This time response curve is sharply accelerated in contrast to that of thyroxine or desiccated thyroid as noted above.

Triiodothyronine is therefore the agent of choice when it is essential to obtain a therapeutic response rapidly, or when a rapid abolition of metabolic effect is desired after withdrawal of the drug. This is necessary relatively rarely: *e.g.*, in psychosis associated

with myxedema; in severe heart failure with myxedema (CAUTION—PROCEED SLOWLY); in a diagnostic trial of thyroid replacement therapy; and, for suppression of thyroid stimulating hormone (TSH), either intermittently in patients with thyroid cancer being treated periodically with radioactive iodine, or continuously in patients with lymphocytic thyroiditis or thyrotropic exophthalmos. Diagnostically, triiodothyronine is useful in evaluating the significance of an elevated radioiodine uptake. One week of therapy with 0.075 mg. of triiodothyronine will by pituitary inhibition result in the normalization of a second radioiodine tracer study in the euthyroid patient but will not lower the high uptake of the thyrotoxic individual. While triiodothyronine is particularly useful in these specific situations, it offers no real advantage over desiccated thyroid in the long term therapy of established hypothyroidism. As in the case of the other preparations, therapy for the hypothyroid patient should be started with small doses (0.01 to 0.025 mg.) and increased gradually to the full maintenance dose which is in the range of 0.075 to 0.125 mg. daily. It should be noted that determinations of protein-bound iodine in the plasma are of no value in assessing effectiveness of therapy since triiodothyronine is not bound by serum protein.

The use of such potent hormones should be limited to (1) those patients in whom replacement therapy is necessary for well documented thyroid deficiency, and (2) those patients in whom it is desired to suppress pituitary-thyroid function for either diagnostic or therapeutic reasons. Their indiscriminate use in the treatment of exogenous obesity, chronic fatigue states, hypometabolism without hypothyroidism, and nonspecific gynecologic disorders is not recommended.—E. C. ALBRIGHT, M. D.

TWO POSTGRADUATE COURSES IN OBSTETRICS

The Woman's Hospital in New York is offering two courses in obstetrics, limited to general practitioners. Each course is approved for 30 hours Category I credit by the American Academy of General Practice.

The courses are entitled: *Ante-partum Care* and *The Conduct of Labor and Delivery*. They will be given from October 16 to 30, 1958.

These are full-time courses running for a week each. Students will be expected to work in the clinics, and in the second course they will be assigned to patients in labor whom they will assist at delivery. Either one or both courses may be elected.

Physicians interested in this postgraduate instruction write Mr. Carl P. Wright, Jr., Woman's Hospital, 141 West 109th Street, New York 25, New York, and an application blank and prospectus will be forwarded.

FILM—"For the Nation's Health"

16-mm. filmograph, color, sound, 15 minutes. 1957

Audience: Personnel in the health, medical, and allied professions.

This Public Health Service orientation film presents a panoramic view of the activities of the principal health agency of the Federal Government. Combining photographs and motion picture film, it shows the growth of the Public Health Service from its inception in 1798, with limited care of the sick and stranded merchant seamen, to its far-flung programs today in hospital and medical care, in medical and biological research, and in public health.

The film is available on a short-term loan from the Surgeon General, Public Health Service (P), Washington 25, D. C.

GASTROENTEROLOGICAL CONVENTION IN NEW ORLEANS OCTOBER 20–22, 1958

The 23rd annual convention of the American College of Gastroenterology will be held at the Jung Hotel in New Orleans, Louisiana, on October 20, 21, 22, 1958, according to Robert T. McCarty, M. D., Milwaukee, who is governor of the American College of Gastroenterology in Wisconsin.

Copies of the program and further information concerning the postgraduate course, which follows the convention, may be obtained by writing to: American College of Gastroenterology, 33 West 60th St., New York 23, N. Y.

Testing for Air Contamination in Industry

As It Looks to Your State Board of Health

IN THIS modern age of industrialization more people than ever are finding work in the confinements of factories. Few plants and operations exist which do not have problems of air contamination due to potentially toxic dusts, fumes, vapors, etc. It then becomes the job of the industrial hygiene engineer to sample these toxic materials and evaluate the results of chemical tests performed by the chemist.

Today's industry is tremendously varied. The many problems encountered range from those of workroom air contamination due to heavy metals (lead, zinc, cadmium) in foundry operations and solvents (carbon tetrachloride, benzene, and related compounds) in cleaning and degreasing operations to insecticide preparations (parathion and arsenic poisons) and by-products of welding, such as iron oxide, ozone, and oxides of nitrogen.

Generally speaking, the industrial hygiene chemist receives his samples in two ways. In one case, the air the worker breathes is sampled and analyzed. For example, an engineer tests air in a foundry to determine the concentration of lead in the atmosphere. At the start of the working day he sets up his apparatus at one or several locations. These locations are either breathing zones (B.Z.), the zone in the immediate vicinity of the worker, or general atmospheres (G.A.), the area away from the operation which would represent the average concentration level in the plant.

Several different air sampling devices are used. In all cases, the flow of air through the apparatus is accurately controlled. A flow of one cubic foot per minute is frequently used. In an electrostatic precipitator the dust or fume particles are "precipitated" out on a cylindrical electrode and then washed off. Vapors are usually sampled by bubbling them through a solution which absorbs or reacts with them. Some vapors may be collected by passing them through a column packed with a loose material, such as small pieces of charcoal, which absorbs the vapors on its surface.

The other method for determining exposure to toxic materials is by using the worker as the sampling device. During the day he continually breathes air which contains not only nitrogen and oxygen, but also dusts or vapors. These materials pass through the lungs into the tissue, blood, and urine. Thus, analyzing a few cubic centimeters of blood or a urine sample can give quite accurate information concerning the concentration of some toxic materials in the air. (Urine analyses are especially applicable for determining exposures to lead, mercury, fluoride, arsenic, selenium, toluene, and benzene.)

Most chemicals may be considered poisonous to a certain degree. Some, such as carbon dioxide, acetone, and ethyl alcohol, are relatively non-toxic. Others—fluorine, carbon tetrachloride and cadmium—are highly toxic. Levels of harmful exposure, or maximum allowable concentrations (MAC) in the air, have been established by the Industrial Commission for almost everything from sawdust to cyanide. MACs are expressed as parts per million for gases and vapors. MACs for dusts, fumes and mists are expressed as milligrams per cubic meter of air. These include mainly metals and acids.

The tests for determining the exact amounts of these compounds in a sample vary greatly. But all methods must be extremely sensitive and selective since the toxic compound is usually present in only microgram quantities (1 microgram = 1 millionth of a gram) along with larger amounts of possibly interfering compounds. Because microgram quantities are much too small to be weighed, other methods are used.

Colorimetric analysis is the most applicable general method. By adding a specific reagent, under controlled conditions and measuring the intensity of the color produced, many compounds and elements can be quantitatively analyzed. A good example of this is the determination of lead in urine. After organic matter has been destroyed by digestion with acid, the sample is neutralized and the acidity is accurately adjusted. Then a small amount of dithizone, a complex organic chemical, is added. Under these conditions the dithizone reacts only with the lead to yield

a highly colored product. The intensity of the color varies with the amount of lead present.

Some compounds fluoresce under proper conditions. This degree of fluorescence can be measured and the amount of the material in question can be calculated. Other compounds, either liquids or solids in a suitable solvent, absorb ultraviolet light, and this phenomenon is the basis of some methods. Some gases are completely absorbed by certain liquids. By passing the gas through the liquid and noting the decrease in volume, percentage of gas in a mixture may be easily determined. If, for example, an air sample is "scrubbed" through pyrogallol, only the oxygen will be removed.

When the samples collected during an engineering survey have been analyzed and the concentrations in air calculated, the results are given to the industrial hygiene engineer for interpretation. By comparing the concentrations at the sampling locations throughout the area with the MACs, the engineer can evaluate the results. If the average level is high, some change is required, either in the production operation or ventilation.—JOHN L. SADENWASSER, *Chemist, Industrial Hygiene Division.*

PHYSICIANS SEEK NUCLEAR RADIATION INFORMATION

A campaign to keep the medical profession in every country fully informed on the effects of nuclear radiation was initiated by physicians of the world at the Opening Plenary Session of the XIIth General Assembly of The World Medical Association. Dr. Louis M. Orr of Orlando, Florida, consultant at the Institute of Nuclear Studies, Oak Ridge, Tennessee, and president-elect of the American Medical Association, addressed the delegates on the subject "*The Biological Effects of Nuclear Radiation*". He reported that

. . . Current nuclear experiments show air and soil contamination being reduced below the danger point to both man and animals

. . . The public faces greater dangers of radiation from the improper, frequent or prolonged use of x-ray than from nuclear experiment "fall-out"

. . . Medical and industrial progress necessitates continued nuclear experimentation as a means of furthering progress in making nuclear energy useful to mankind.

Doctor Orr reminded the Assembly that both vaccination and anesthesia were subjected to widespread propaganda and disrepute at their inception, but have now become basic elements in the practice of medical science.

During the past several years, The World Medical Association has considered several resolutions on nuclear experimentation. Some of the national medical associations that comprise the membership of The World Medical Association have urged that their physicians be provided with factual information on nuclear radiation. The physicians note that nuclear radiation elicits great concern among the peoples of the world because it is in the realm of the unknown and there is a belief that it is harmful to human life. The medical profession is the logical source for informing the people of the true facts on nuclear experimentation. To fulfill this obligation to the people it must be fully informed of the scientific developments in this field devoid of the political and emotional factors that have become associated with this topic.

In planning a program to assist the national medical associations in providing scientific information to the physicians of their countries, the Council of The World Medical Association noted that in certain member countries the biological effects of radiation are openly discussed and only the process of production of these substances is kept secret. Hence, medical associations in these countries will be invited to provide the Headquarters Secretariat with literature on the latest scientific developments in the field of nuclear experimentation. The Secretariat will send this literature to the member associations for distribution to the physicians of their countries.

Dr. Louis H. Bauer, Secretary General of The World Medical Association, announced that the literature exchange program would be effected before the beginning of 1959 from United Nations and United States publications on this important scientific field.

. . . . THE PRESIDENT'S PAGE . . . .

Physician Heed Thyself

THE physician's role as a citizen, in the political theatre about to open, need not be the principal one, nor should it be one of silent observation. Too long have physicians held that medicine and politics are not miscible. Like the popular conception about the ostrich avoiding all difficulties by burying his head in the sand, so also does the concept of medicine and politics not mixing, lack in logic.

We as physicians have spent many long years of preparation to practice medicine, and would be most happy to be able to practice sound medicine without interference from politicians, government, cultists, do-gooders and effervescent social, or should I say socialist workers.

Such, however, is not the case; and it becomes necessary, as a matter of self preservation, for the physician to take an active part in being a citizen and a voter lest the politician take over.

It is not enough for the physician to be just a good physician treating the ills of his patients according to accepted standards of sound, scientific, medical teaching. He must not only have knowledge of all national, state and local legislation, but he must also know the men seeking office, their attitude towards medicine, their opinion relative to the free enterprise system which built our country. All this and more, the physician as a citizen owes to himself and to those who seek his advice on matters political.

Particularly is this true at grass roots level, for many national legislators started on their careers as local office holders and carried along with their ascendency on the political ladder, the true philosophy of medicine as explained to them by the family physician; or, lacking such concept, because some physician was too busy, carried with them, misinformation supplied by those who would ride on the coat-tails of medicine.

Dr. Ervin L. Bernhart, a past president of our Society, in his inaugural address at the conference of presidents and other officers of medical associations at the A.M.A. meeting on June 22, 1958, stated:

> "What kind of drought has spread over the grass roots of American medicine? What kind of reclamation projects are needed to restore vigor to these dead and dying grass roots? Is there anything more important in the interest of preserving and improving the quality of medical care?"

The physician in the urban areas of the state has just as much at stake as his rural colleague. Legislation, enacted by legislators who are uninformed or misinformed as to the true position of medicine in the matter, affects the entire profession.

Legislators are elected by voters. Voters are patients. Physicians are citizens.

Informed citizens must share their information with those less informed—or shall we say:

> *"Politics we bar, they are not our bent:*
> *On the whole we are not intelligent."*

Physician heed thyself!

Jerome W. Forsth

"Wake in our breast the living fires,
The Holy faith that warmed our sires. . . ."
OLIVER WENDELL HOLMES, M. D.

. . . gleanings from the Section on Medical History

It was a physician, Dr. J. Wesley Carhart, of Racine, who invented the first automobile, the orginal forerunner of all self-propelled vehicles on the road today.

Back in 1873, Doctor Carhart, who also served his community as Methodist minister, conceived, built and operated the "Spark," the first motor car. It was a two-cylinder steam engine with wagon wheels. When it came lumbering down the streets, it created a sensation.

J. W. Carhart, M. D.

Horse owners described Doctor Carhart's contrivance as a "crude, noisy, hideous buggy." They tried to procure injunctions to restrain the inventor from operating the blatant machine in town. They succeeded when a valuable horse, owned by Industrialist J. I. Case, later an automobile manufacturer himself, was frightened by the "Spark" and was killed in the ensuing runaway.

Racine residents of that time told their grandchildren later that the car huffed and puffed, snorted and smoked, and that it was a frightening thing. But an editor called it a "prophecy of the motor age to come."

It impressed the Wisconsin legislature sufficiently to offer, a few years later, $10,000 to the inventor of a vehicle which could run successfully over a specified route, from Green Bay to Watertown to Janesville to Madison.

The Section on Medical History, busy doing research on the early days of medicine in Wisconsin, uncovered the story of Doctor Carhart and his car. Much of the Section's effort is directed to collecting information for the Medical Museum of Wisconsin, to be built in Prairie du Chien in the next few years.

From the files of historians comes this description of the physician's steamer:

"It is built the same as any ordinary buggy, except the hind part, which is so constructed that the big boiler drops through the rear axle-tree. The boiler and engines rest on rear springs. The buggy is steered by means of a lever.

"The whole thing weighs about 600 pounds. It is so simple in construction and ease of management that a lady can control and guide it. The fuel (soft coal) was stored under the driver and was passed back between his legs to the firebox. The machine ran about four miles an hour."

In 1903 the "Horseless Age," a trade publication published in New York, hailed Doctor Carhart as the "Father of the Automobile."

In 1905, Doctor Carhart was a guest of the government of France at the International Automobile Exposition in Paris, and he received a cash award and a certificate of honor.

The versatile gentleman found time to serve as pastor of the First Methodist–Episcopal church in Racine. About 1874 he moved to Oshkosh and preached for several years there before heading in the early 1880's for Texas. There he devoted himself to medicine and built a reputation as an outstanding skin and nerve specialist in Austin and San Antonio.

His invention of the "Spark" was not profitable, perhaps because he didn't bother with patents, but it was a great source of pride to him. After he died in 1914, the Racine Times, in an editorial, stated:

"Now has died a man who helped make Racine famous in the '70s.

"Older residents will remember seeing sparks and cinders shooting up 30 feet in the air from a smoke stack on his machine. There was a noise like unto a present-day switch engine hauling a string of empties. Few folks inspected the contraption carefully, for they were too busy running for the tall timber to be worrying about the mechanical features of the invention.

"The main question was how to dodge it.

"This invention served to prepare men's minds for the coming of the modern automobile, and thus make it rather more easy for Racine to initiate the projects which gave the city its present high position in the motor manufacturing world."

The editorial was headed: "Breaking the Path."

STACKS

the Wisconsin Medical Journal

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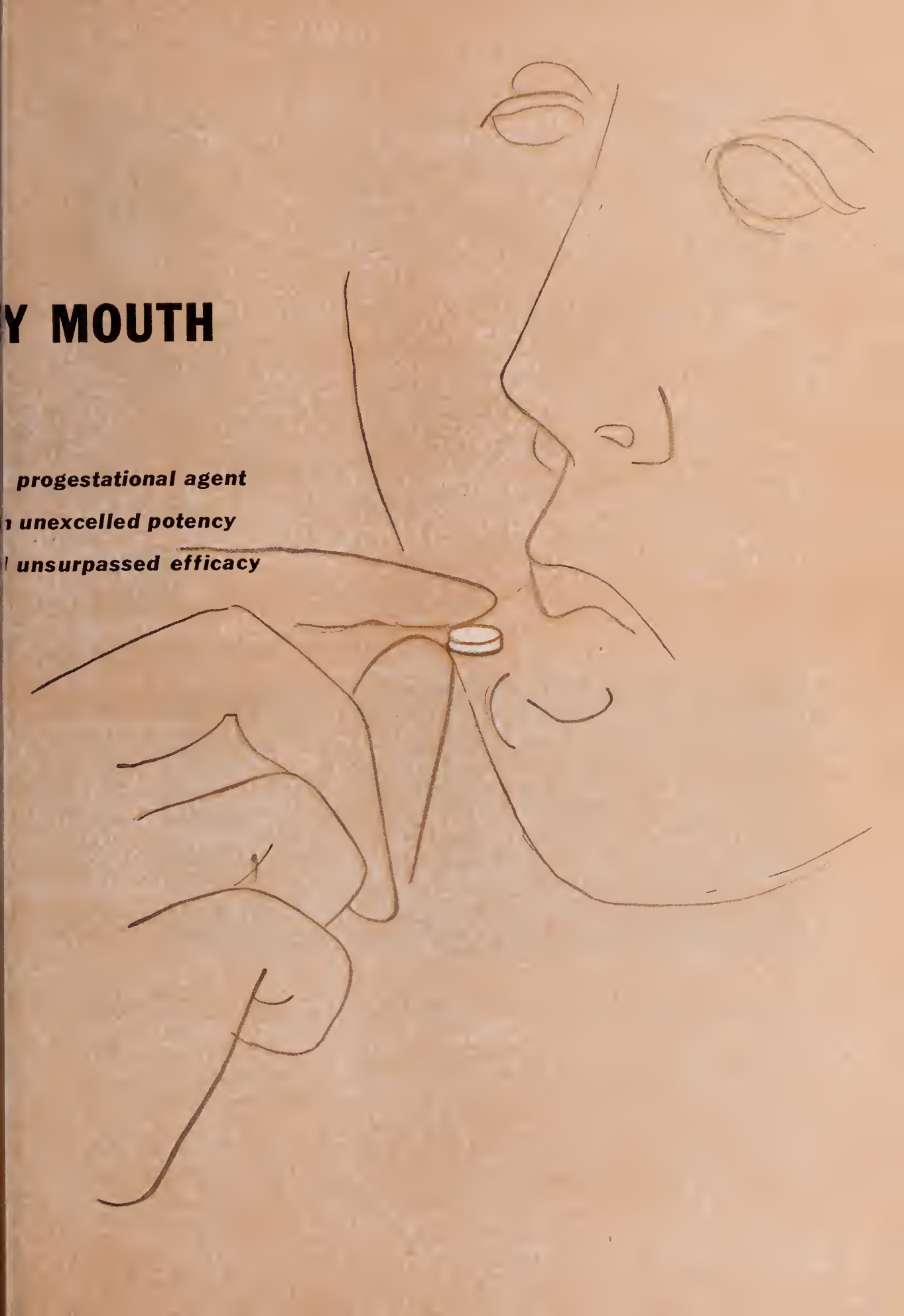
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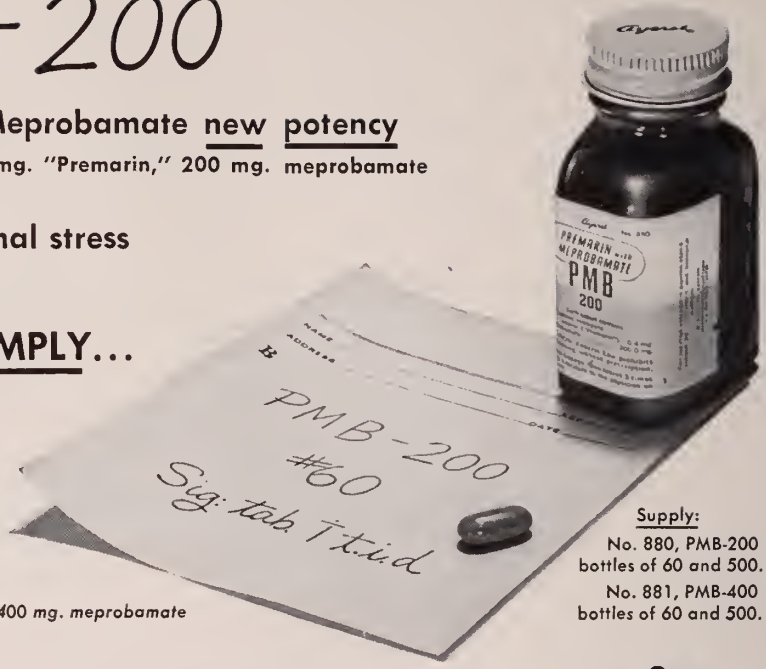

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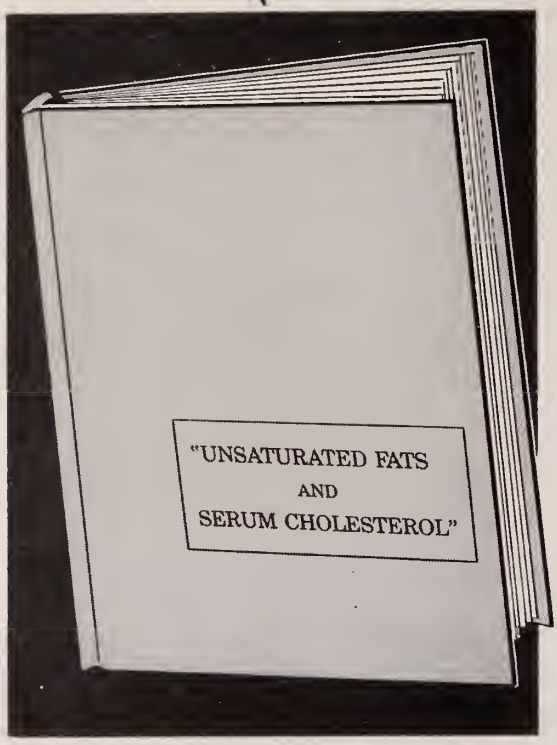

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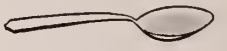


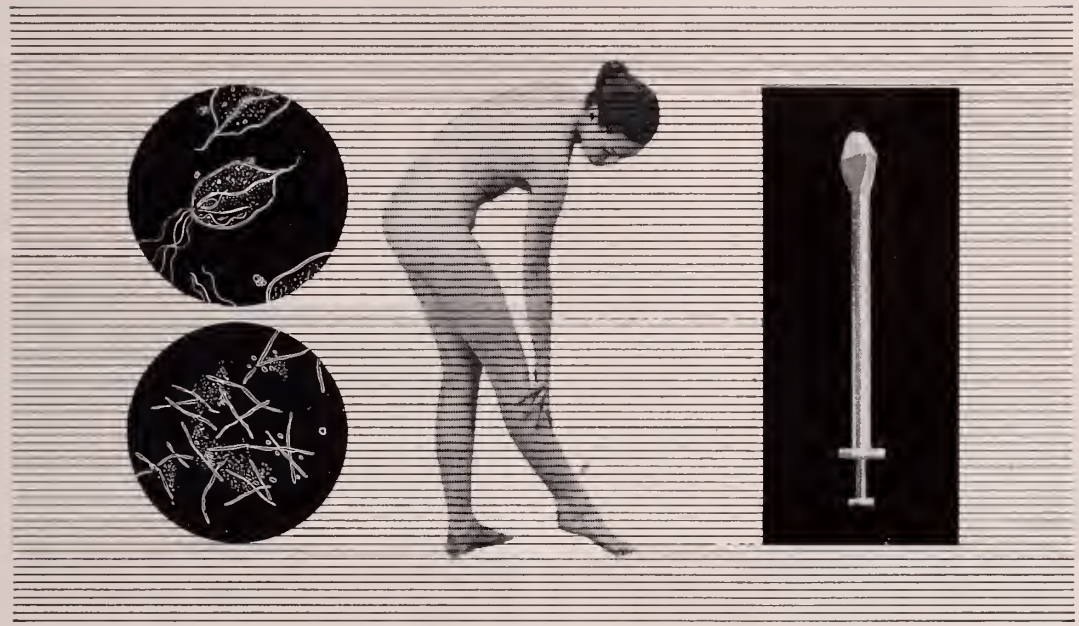
Each **TABLESPOONFUL** *of* **MAZOLA** *Provides approximately:*

LINOLEIC ACID . . . . . 7.4 Gm.
Sitosterols . . . . . 130.0 mg.
Natural tocopherols . . . . . 15.0 mg.
Cholesterol 0
Weight . . . . . 14 Gm. Calories 126
Total unsaturated Fatty Acids—85%

TYPICAL AMOUNTS PER DIET

For a 3600 calorie diet . . . . . 3 Tbsp.
For a 3000 calorie diet . . . . . 2.5 Tbsp.
For a 2000 calorie diet . . . . . 1.5 Tbsp.

FOR FLAGELLATE AND FUNGAL VAGINITIS



Floraquin®

Destroys Common Vaginal Pathogens; Rebuilds Normal Bacterial Barrier

Whenever a woman complains of vaginal discharge with pruritus, a trichomonal infection[1] must be suspected. Moniliasis, the second most frequent cause[2] of leukorrhea, often occurs[3] in conjunction with diabetes mellitus, pregnancy and estrogen or broad spectrum antibiotic therapy. Commonly used douches wash away normal acid secretions and protective Döderlein bacilli, thus tending to aggravate the problem.

Floraquin, containing Diodoquin® (diiodohydroxyquin, U.S.P.), eliminates infection and provides boric acid and sugar to restore the acidic pH which favors replacement of pathogens by normal Döderlein bacilli. The danger of recurrence is thus minimized.

Pitt reports[2] consistently good results after daily vaginal insufflation of Floraquin powder for three to five days, followed by acid douches and the daily insertion of Floraquin vaginal tablets throughout one or two menstrual cycles.

Intravaginal Applicator for Improved Treatment of Vaginitis—

This smooth, unbreakable, plastic plunger device is designed for simplified insertion of Floraquin tablets by the patient; it places tablets in the fornices and thus assures coating of the entire vaginal mucosa as the tablets disintegrate. A Floraquin applicator is supplied with each box of 50 tablets.

G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

1. Davis, C. H.: Trichomonas Vaginalis Infections: A Clinical and Experimental Study, J.A.M.A. *157:*126 (Jan. 8) 1955.
2. Pitt, M. B.: Leukorrhea, Causes and Management, J.M.A. Alabama *25:*182 (Feb.) 1956.
3. Lang, W. R.: Recent Advances in Vaginitis, Philadelphia Med. *51:*1494 (June 15) 1956.

SEARLE

in all diarrheas

CREMOMYCIN®

SUCCINYLSULFATHIAZOLE—NEOMYCIN SUSPENSION WITH PECTIN & KAOLIN

EXPERIENCE

MORE THAN 16 MILLION DOSES ADMINISTERED WITH SAFETY AND EFFICACY.

regardless of etiology

MSD MERCK SHARP & DOHME

DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

CREMOMYCIN is a trademark of Merck & Co., Inc.

Comments by investigators on

Robaxin®

(Methocarbamol Robins, U.S. Pat. No. 2770649)

Robins

– the remarkably efficient skeletal muscle relaxant, unique in chemical formulation, and outstanding for sustained action and relative freedom from adverse side effects.

PUBLISHED REFERENCES: 1. Carpenter, E. B.: Southern Medical Journal 51:627, 1958. 2. Forsyth, H. F.: J.A.M.A. 167:163, 1958. 3. Little, J. M., and Truitt, E. B., Jr.: J. Pharm. & Exper. Therap. 119:161, 1957. 4. Morgan, A. M., Truitt, E. B., Jr., and Little, J. M.: J. Am. Pharm. Assn., Sci. Ed. 46:374, 1957. 5. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:160, 1958. 6. Park, H. W.: J.A.M.A. 167:168, 1958. 7. Truitt, E. B., Jr., and Patterson, R. B., Proc. Soc. Exper. Bio. & Med. 95:422, 1957. 8. Truitt, E. B., Jr., Patterson, R. B., Morgan, A. M., and Little, J. M.: J. Pharm. & Exper. Therap. 119:189, 1957.

Supply: Tablets (white, scored), 0.5 Gm., bottles of 50 and 500.

A. H. ROBINS CO., INC., Richmond 20, Va.

Ethical Pharmaceuticals of Merit since 1878

Summary of four new published clinical studies:

Robaxin Beneficial in 95.6% of Cases of Acute Skeletal Muscle Spasm[1, 2, 5, 6]

CONDITION	NO. PATIENTS	RESPONSE			
STUDY 1[1]		"marked"	moderate	slight	none
Skeletal muscle spasm secondary to acute trauma	33	26	6	1	—
STUDY 2[2]		"pronounced"			
Herniated disc	39	25	13	—	1
Ligamentous strains	8	4	4	—	—
Torticollis	3	3	—	—	—
Whiplash injury	3	2	1	—	—
Contusions, fractures, and muscle soreness due to accidents	5	3	2	—	—
STUDY 3[5]		"excellent"			
Herniated disc	8	6	2	—	—
Acute fibromyositis	8	8	—	—	—
Torticollis	1	—	—	1	—
STUDY 4[6]		"significant"			
Pyramidal tract and acute myalgic disorders	30	27	—	2	1
TOTALS	138	104	28	4	2
		(75.3%)	(20.3%)		

THE JOURNAL
American Medical Association

"In the author's clinical experience, methocarbamol has afforded greater relief of muscle spasm and pain for a longer period of time without undesirable side effects or toxic reactions than any other commonly used relaxants . . ."[2]

THE JOURNAL
American Medical Association

"An excellent result, following methocarbamol administration, was obtained in all patients with acute skeletal muscle spasm."[5]

THE JOURNAL
American Medical Association

"In no instance was there any significant reduction in voluntary strength or intensity of simple reflexes."[6]

Southern Medical Journal

"This study has demonstrated that methocarbamol (Robaxin) is a superior skeletal muscle relaxant in acute orthopedic conditions."[1]

why California table wine in the low-sodium diet?

TABLE I[1]

	No. specimens examined	Sodium (mg./100 cc.) Mean
Musts (crushed white grapes)	9	1.63
California Red Table Wines	82	5.56
California White Table Wines	73	5.44
California Dessert Wines	104	7.10

*D*ietary restriction of sodium has become a standard procedure in the control of edema associated with cirrhosis of the liver, congestive heart failure, certain kidney ailments, toxemias of pregnancy, during digitalization and in drug-induced diuresis.

Unfortunately sodium-restricted diets tend to be flat, tasteless, monotonous, leading toward failure of dietary cooperation by the patient.

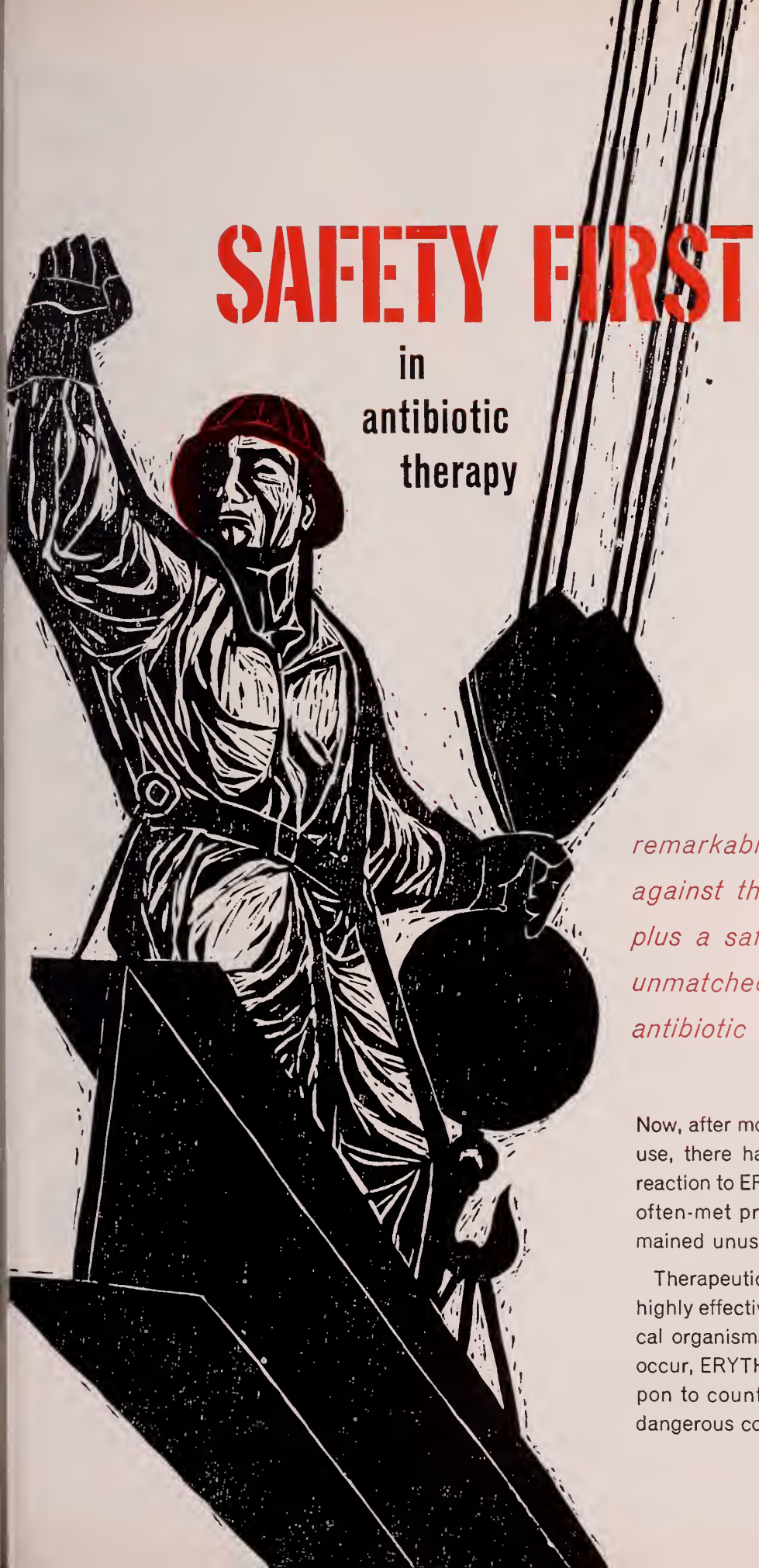
In such cases California table wine may be employed safely as well as to advantage in making the food more palatable without adding significant amounts of sodium .

In a recent study[1] it was shown that California table wines are remarkably low in sodium content—less than 10 mg. per 100 cc. (3½ ounce glass).

Since recent research [2,3,4] has also shown that wine stimulates a lagging appetite and aids digestion while adding a sparkle to any meal—why not encourage the moderate use of wine by the patient on a restricted dietary, as well as by the sufferer from anorexia, the post-surgical, convalescent or geriatric patient?

May we send you a copy of "Uses of Wine in Medical Practice"? A copy is available to you, at no expense, by writing to: Wine Advisory Board, 717 Market Street, San Francisco 3, California.

1. Lucia, S. P. and Hunt, M. L.: Am. J. Digest. Dis. 2:26 (Jan.) 1957.
2. Goetzl, F. R.: Permanente Found. M. Bull. 8:72 (April) 1950.
3. Irvin, D. L. and Goetzl, F. R.: Permanente Found. M. Bull. 9:119 (Oct.) 1951.
4. Irvin, D. L.; Durra A., and Goetzl, F. R.: Am. J. Digest. Dis. 20:117 (Jan.) 1953.



SAFETY FIRST

in antibiotic therapy

remarkable effectiveness against the cocci– plus a safety record unmatched in systemic antibiotic therapy

Now, after more than six years of extensive use, there has not been a single serious reaction to ERYTHROCIN. Additionally, the often-met problem of resistance has remained unusually low with ERYTHROCIN.

Therapeutically, you'll find ERYTHROCIN highly effective against the majority of coccal organisms. Where severe viral attacks occur, ERYTHROCIN may well be the weapon to counteract those dangerous complications.

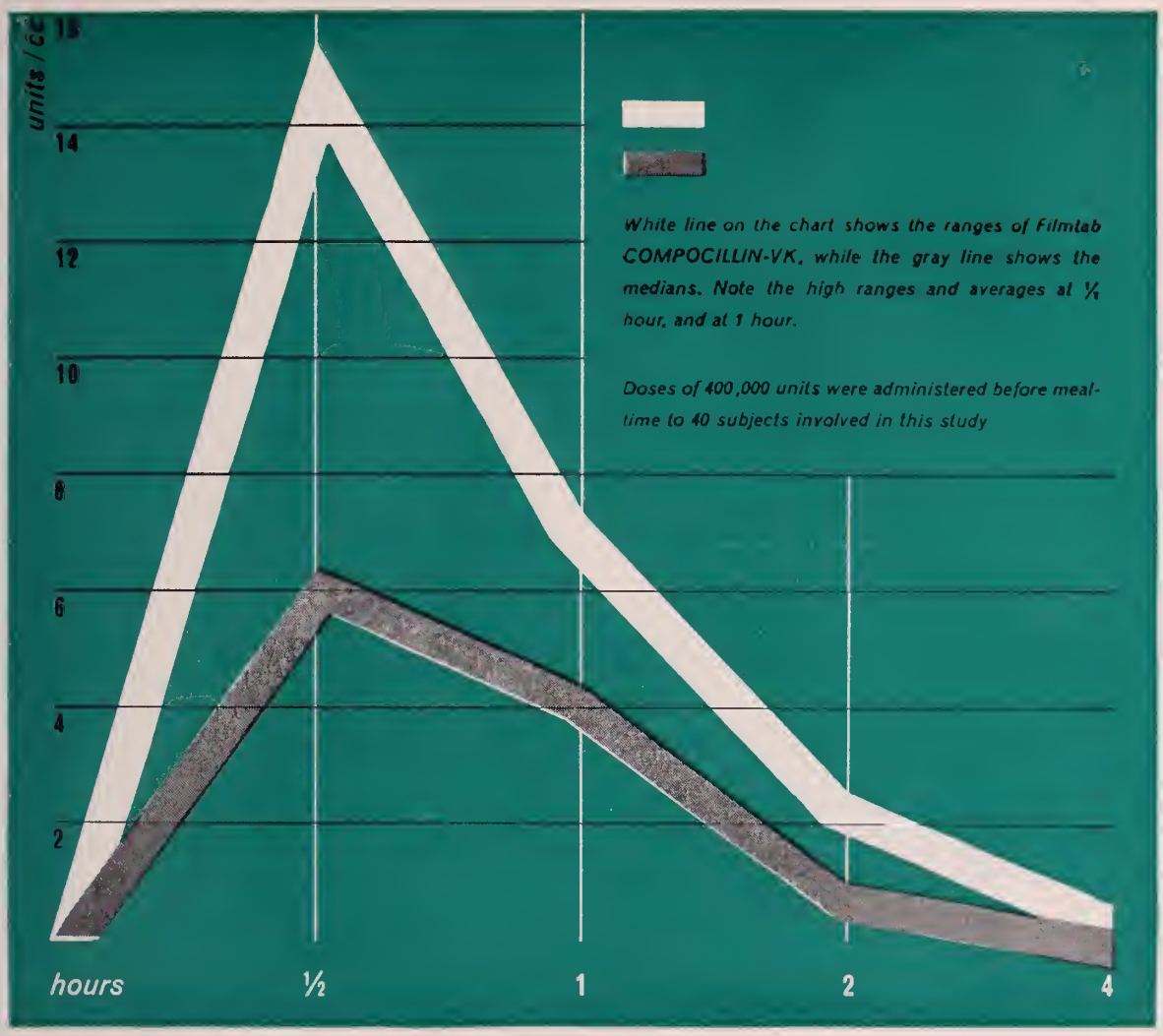
Abbott

the higher blood levels of

COMPOCILLIN-VK®

Potassium
Penicillin V

609136



Now, in both Filmtab and Oral Solution, patients get high penicillin V blood levels with Compocillin-VK. Note the chart. Concentrations are three times higher than an equivalent dose of potassium penicillin G.

Compocillin-VK is indicated whenever you desire oral penicillin therapy. In severe infections, oral penicillin should be supplemented by parenteral therapy to obtain the maximum therapeutic response.

Indications:

Against all organisms sensitive to oral penicillin therapy. For prophylaxis and treatment of complications in viral conditions. And as a prophylaxis in rheumatic fever and rheumatic heart disease.

Dosage:

Depending on the severity of the infection, the usual adult dose is 125 to 250 mg. (200,000 to 400,000 units) every four to six hours. For children, dosage may be reduced in proportion to body weight.

Supplied:

In Filmtabs, representing 125 mg. (200,000 units) of potassium penicillin V, bottles of 50 and 100. In 250 mg. (400,000 units), bottles of 25 and 100.

For Oral Solution, Compocillin-VK comes in dry granules for easy reconstitution with water. Cherry-flavored, the granules come in 40-cc. and 80-cc. bottles. Each 5-cc. teaspoon of solution represents 125 mg. (200,000 units) of potassium penicillin V.

Compocillin-V® Oral Suspension (Ready-Mixed), Hydrabamine Penicillin V, Abbott, comes in 40-cc. and 80-cc. bottles. Each tasty, banana-flavored 5-cc. teaspoonful represents 180 mg. (300,000 units) of penicillin V. At all pharmacies. Abbott

indications:
Against a wide range of staphylococcal, streptococcal, pneumococcal and enterococcal infections. A drug of choice for treating serious infections caused by organisms that resist all other antibiotics.

dosage:
Administered intravenously. In pneumococcal, streptococcal and enterococcal infections, a dosage of 25 mg./Kg. will usually be adequate. Majority of staphylococcal infections will be controlled by 25 to 50 mg./Kg. per day. It is recommended that the daily dosages be divided into two or three equal parts at eight-or 12-hour intervals.

supplied:
In vials containing a sterile, lyophilized powder, representing 500 mg. of ristocetin A activity.

SPONTIN®

(RISTOCETIN, ABBOTT)

provides bactericidal action against coccal infections

provides successful short-term therapy against endocarditis[1]

provides clinical effectiveness against resistant staphylococci and enterococci[2]

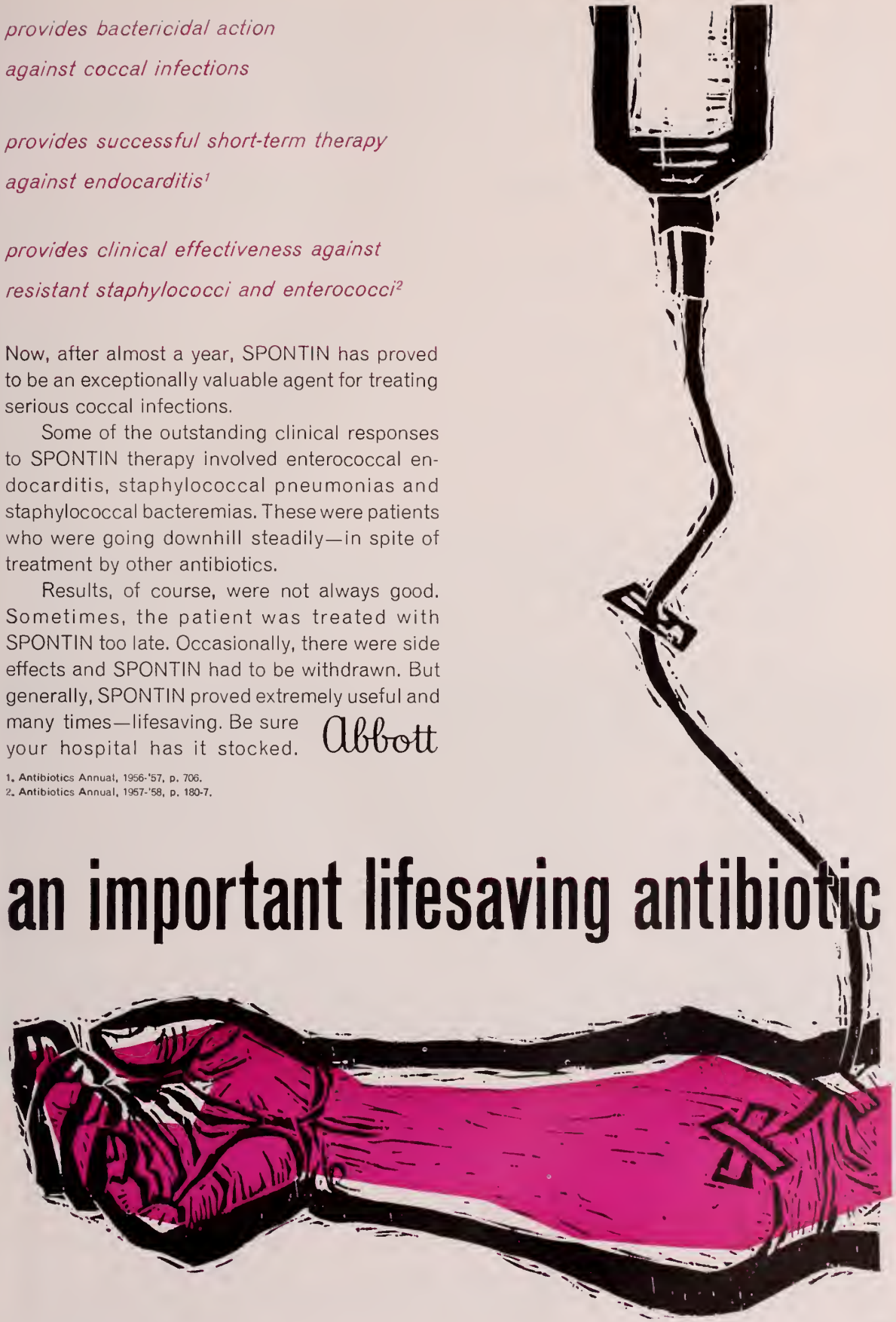
Now, after almost a year, SPONTIN has proved to be an exceptionally valuable agent for treating serious coccal infections.

Some of the outstanding clinical responses to SPONTIN therapy involved enterococcal endocarditis, staphylococcal pneumonias and staphylococcal bacteremias. These were patients who were going downhill steadily—in spite of treatment by other antibiotics.

Results, of course, were not always good. Sometimes, the patient was treated with SPONTIN too late. Occasionally, there were side effects and SPONTIN had to be withdrawn. But generally, SPONTIN proved extremely useful and many times—lifesaving. Be sure your hospital has it stocked. Abbott

1. Antibiotics Annual, 1956-'57, p. 706.
2. Antibiotics Annual, 1957-'58, p. 180-7.

an important lifesaving antibiotic



ANNUAL CLINICAL CONFERENCE

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Lectures — Teaching Demonstrations

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The CHICAGO MEDICAL SOCIETY ANNUAL CLINICAL CONFERENCE should be a MUST on the calendar of every physician. Plan now to attend and make your reservation at the Palmer House.

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A treatment and rehabilitation center providing inpatient and outpatient services for those disabled as a result of neurological disorders.

Diagnostic Studies — Occupational Therapy
Physical Medicine — Vocational Counseling
Speech Therapy — Therapeutic Recreation

POSTGRADUATE CALENDAR

NOVEMBER 6–7–8: GENERAL PRACTICE—1958, University of Wisconsin (in cooperation with Wisconsin Academy of General Practice). $5.00 registration, $30.00 tuition. AAGP Category I credit. Office of Postgraduate Education, Univ. of Oklahoma Medical Center, 801 N.E. 13th Street, Oklahoma City, Okla.

NOVEMBER 17–19: FRACTURES FOR GENERAL PHYSICIANS, Univ. of Minnesota. Department of Continuation Medical Education, 1342 Mayo Memorial, Univ. of Minnesota, Minneapolis 14, Minn.

NOVEMBER 17–22: NEUROLOGY AND NEUROSURGERY FOR THE GENERAL PHYSICIANS, Univ. of Minnesota, Department of Continuation Medical Education, 1342 Mayo Memorial, Univ. of Minnesota, Minneapolis 14, Minn.

NOVEMBER 19: ANO RECTAL DISEASES (one day meeting), Univ. of Oklahoma. Office of Postgraduate Education, Univ. of Oklahoma Medical Center, 801 N.E. 13th Street, Oklahoma City, Okla.

NOVEMBER 20: CIRCUIT PROGRAM, Hardware Mutuals Auditorium, Stevens Point. Afternoon program from 2:00–6:00 p.m. $5.00. hours AAGP Category I credit. Fever of Unknown Origin, Common Neurologic Problems, Common Skin Diseases, Gynecology. (State Medical Society teaching program).

NOVEMBER 20–22: PHYSICAL MEDICINE FOR SPECIALISTS, Univ. of Minnesota. Department of Continuation Medical Education, 1342 Mayo Memorial, Univ. of Minnesota, Minneapolis 14, Minn.

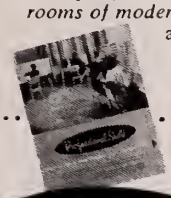
DECEMBER 2–5: A.M.A. CLINICAL SESSION, Minneapolis.

For the doctor who must do his own dispensing

Master Styling Room Ensemble

● Today's eye doctor must satisfy the growing demand of his patients for fashion, style and service. And at the same time, in the interest of more successful operation, he must increase his own efficiency.

After several years of research and study under actual operating conditions, PROFESSIONAL SUITE presents this matched line of equipment and furniture — *specifically designed and engineered for the modern styling and dispensing rooms of modern doctors* . . . sold in matched ensembles for large, medium and smaller offices. Individual pieces may also be purchased.



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I'd like to take a look at your PROFESSIONAL SUITE catalog *(no obligation, of course)*. Dept. No. WM108

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PREVENT
both cause and fear of
ANGINA ATTACKS

proven safety for long-term use

Miltrate*

NEW DOVETAILED THERAPY COMBINES IN ONE TABLET

prolonged relief from anxiety and tension with **MILTOWN®** — The *original* meprobamate, discovered and introduced by Wallace Laboratories

+

sustained coronary vasodilation with **PETN** — pentaerythritol tetranitrate a leading, long-acting nitrate

"In diagnosis and treatment [of cardiovascular diseases] . . . the physician must deal with both the emotional and physical components of the problem simultaneously."[1]

The addition of Miltown to PETN, as in Miltrate,"...appears to be more effective than [PETN] alone in the control of coronary insufficiency and angina pectoris."[2]

Miltrate is recommended *for prevention* of angina attacks, *not for relief* of acute attacks.

Supplied: Bottles of 50 tablets.
Each tablet contains: 200 mg. Miltown + 10 mg. pentaerythritol tetranitrate.
Usual dosage: 1 or 2 tablets q.i.d. *before meals* and at bedtime.
Dosage should be individualized.

For clinical supply and literature, write Dept. 60A

1. *Friedlander, H. S.: The role of ataraxics in cardiology. Am. J. Card.* **1**:*395, March 1958.*
2. *Shapiro, S.: Observations on the use of meprobamate in cardiovascular disorders. Angiology* **8**:*504, Dec. 1957.*

CML-7186

WALLACE LABORATORIES, *New Brunswick, N. J.*

*TRADE-MARK

When the bronchial tree has too much "bark"

make cough **MORE PRODUCTIVE, LESS DESTRUCTIVE**

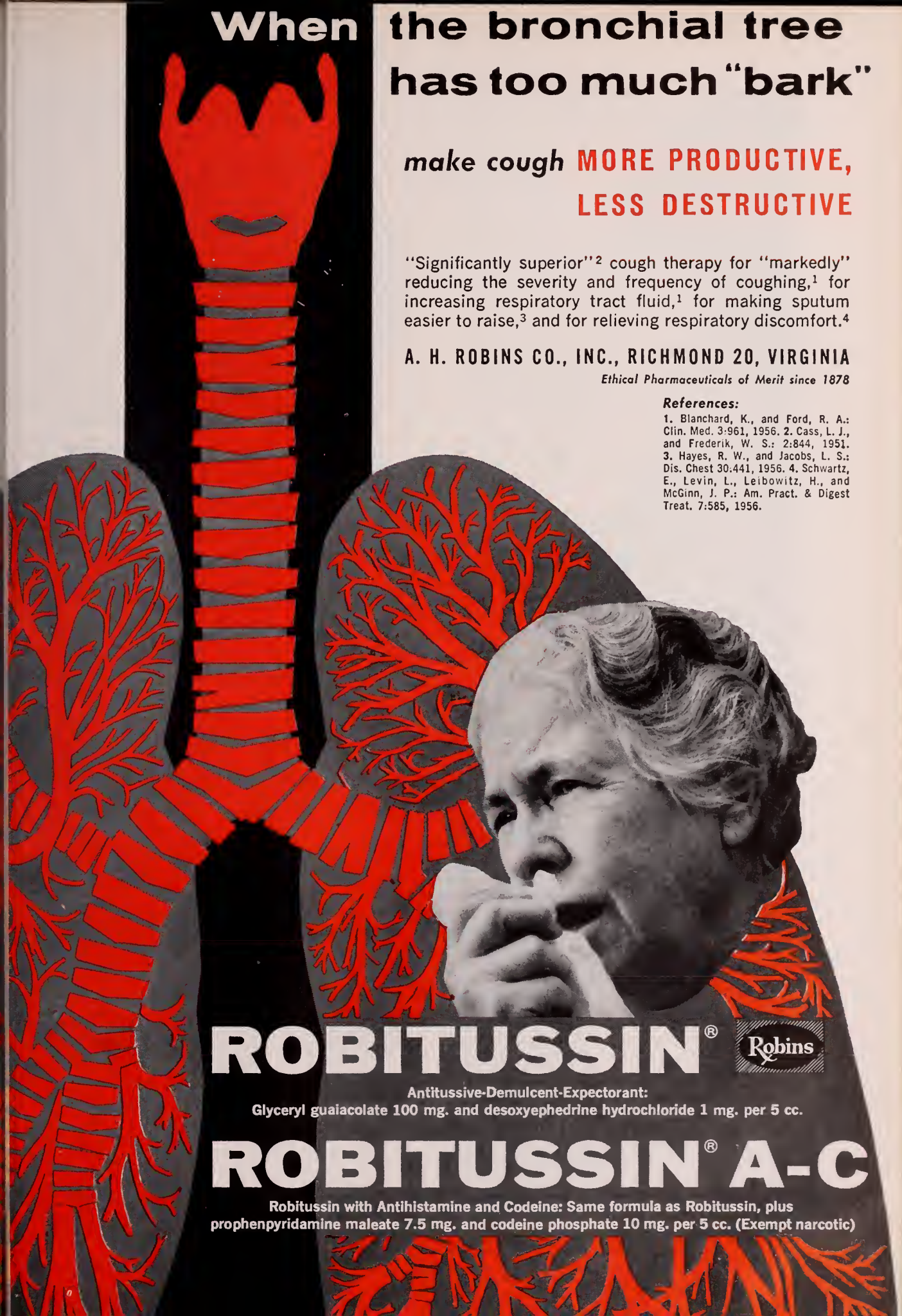
"Significantly superior"[2] cough therapy for "markedly" reducing the severity and frequency of coughing,[1] for increasing respiratory tract fluid,[1] for making sputum easier to raise,[3] and for relieving respiratory discomfort.[4]

A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA

Ethical Pharmaceuticals of Merit since 1878

References:

1. Blanchard, K., and Ford, R. A.: Clin. Med. 3:961, 1956. 2. Cass, L. J., and Frederik, W. S.: 2:844, 1951. 3. Hayes, R. W., and Jacobs, L. S.: Dis. Chest 30:441, 1956. 4. Schwartz, E., Levin, L., Leibowitz, H., and McGinn, J. P.: Am. Pract. & Digest Treat. 7:585, 1956.



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Robins

Antitussive-Demulcent-Expectorant:
Glyceryl guaiacolate 100 mg. and desoxyephedrine hydrochloride 1 mg. per 5 cc.

ROBITUSSIN® A-C

Robitussin with Antihistamine and Codeine: Same formula as Robitussin, plus prophenpyridamine maleate 7.5 mg. and codeine phosphate 10 mg. per 5 cc. (Exempt narcotic)

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Established 1865

ARTIFICIAL LIMBS
ORTHOPEDIC APPLIANCES
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Has available at all times a complete line of film and chemicals, plus the equipment and accessory items needed to make your X-ray department operate efficiently.

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Protection Against Loss of Income from Accident and Sickness as Well as Hospital Expense Benefits for You and All Your Eligible Dependents.

ALL PREMIUMS COME FROM PHYSICIANS SURGEONS DENTISTS ALL BENEFITS GO TO

PHYSICIANS CASUALTY & HEALTH ASSOCIATIONS
OMAHA 31, NEBRASKA
Since 1902

*Compazine**

nausea and vomiting

—from virtually any cause

- in pregnancy—pre- and postoperative states—gastroenteritis—alcoholism—cancer and chronic diseases
- control is achieved with low dosage—usually 15 to 20 mg. daily—and often within a half hour after the first oral dose

'Compazine' is remarkable for its freedom from drowsiness. Patients carry on normal activities and often experience an actual alerting effect.

. . .for immediate control of severe vomiting:

Ampuls, 2 cc. (5 mg./cc.)

NEW: Multiple dose vials, 10 cc. (5 mg./cc.)

—always carry one in your bag

Also available:

Tablets, 5, 10 and 25 mg., in bottles of 50 and 500.
Spansule† *capsules,* 10, 15 and 30 mg., in bottles of 30 and 250.
Suppositories, 5 and 25 mg., in boxes of 6.
Syrup, 5 mg./teaspoonful (5 cc.), in 4 fl. oz. lightproof bottles.

Smith Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off. for prochlorperazine, S.K.F.
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NEW styling for known standard

To diabetics and their physicians, CLINITEST means rapid *and* reliable urine-sugar testing—standardized for accurate results every time. And now, the new streamlined model (No. 2105) gives your diabetics this standard test in the best looking, most efficient form.

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- **functional:** full-view test tube always in place
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Model No. 2105 CLINITEST Urine-Sugar Analysis Set contains everything needed for accurate standardized testing: bottle of 36 CLINITEST Reagent Tablets, test tube, unbreakable dropper. color scale—instruction sheet, analysis record, diabetic's identification card

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now—an antibiotic troche that

STOPS COUGH TOO

The *cough control* provided by homarylamine (a non-narcotic antitussive) approximates that of codeine.

Three antibiotics (bacitracin, tyrothricin, neomycin) act in combination against a wide variety of pathogens—with little danger of side reactions.

The anesthetic-analgesic effect of benzocaine brings *soothing relief* to inflamed tissues of mouth and throat.

PENTAZETS now extend the therapeutic usefulness of convenient troche medication. Each pleasant-tasting PENTAZETS troche acts promptly against the most bothersome aspects of mouth and throat irritations.

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Pentazets®

antitussive—antibiotic—anesthetic—analgesic troches

MSD MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

Dosage: Three to 5 troches daily for 3 to 5 days.
Supplied: In vials of 12.
PENTAZETS is a trademark of Merck & Co., Inc.

general use...
in general practice

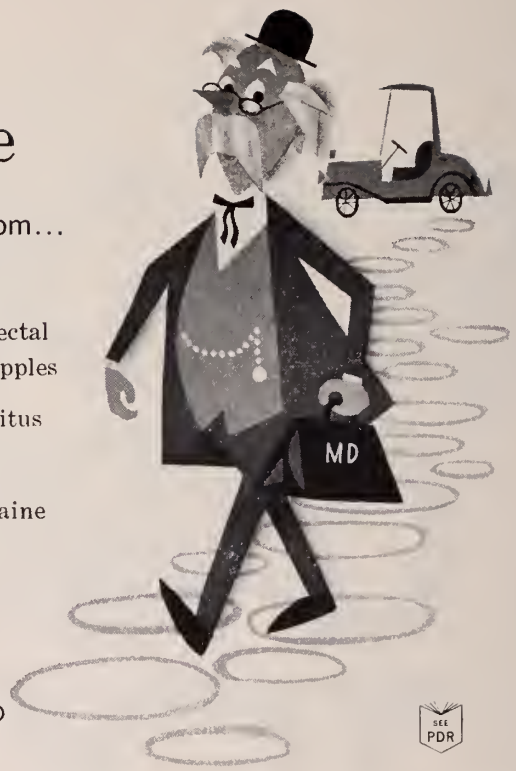
fast, effective and long-lasting relief from...

BURNS – sunburn, cooking, ironing

PAIN – hemorrhoids and inoperable anorectal conditions, cuts and abrasions, cracked nipples

ITCHING – insect bites, poison ivy, pruritus

The water-soluble, nonstaining base melts on contact with the tissue, releasing the Xylocaine for immediate anesthetic action. It does not interfere with the healing processes.



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XYLOCAINE®
(brand of lidocaine*)

OINTMENT 2.5% & 5%

*U.S. PAT. NO. 2,441,498 MADE IN U.S.A.

For Real Pain ...give real relief:

A.P.C. WITH Demerol® tablets

Each tablet contains:

Aspirin	200 mg.	(3 grains)
Phenacetin	150 mg.	(2½ grains)
Caffeine	30 mg.	(½ grain)
Demerol hydrochloride	30 mg.	(½ grain)

Average Dose:

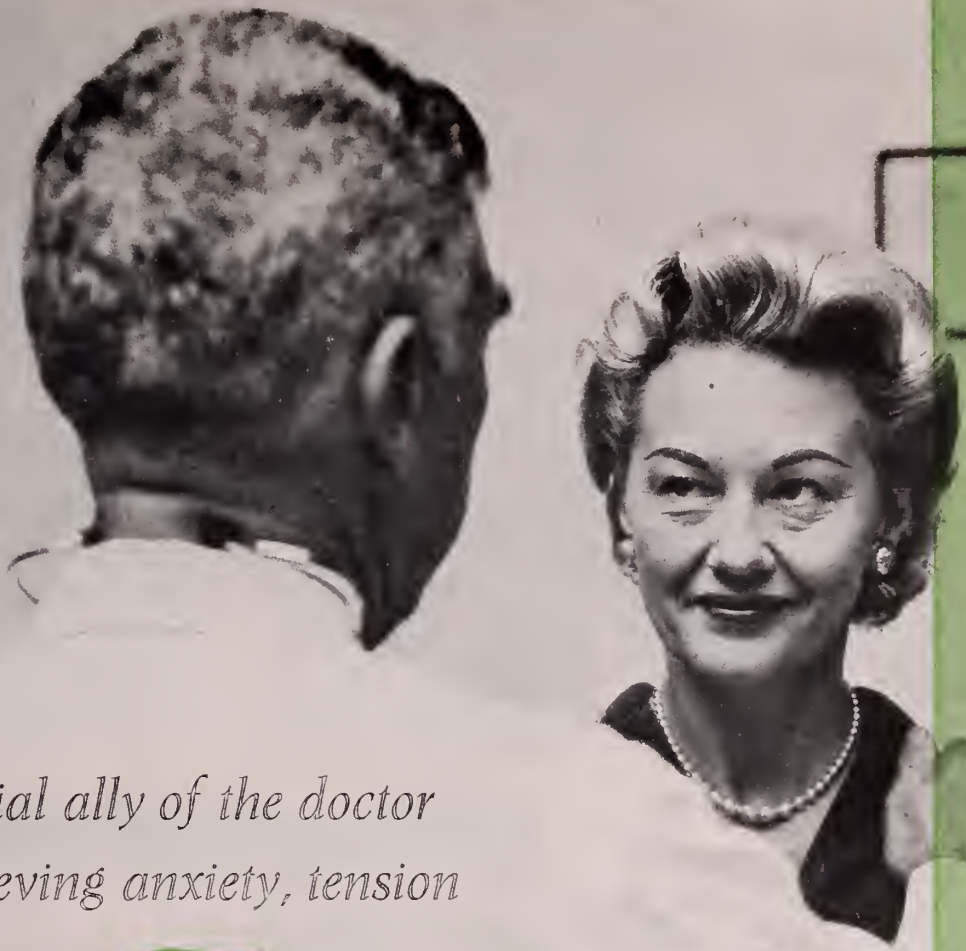
1 or 2 tablets.

Narcotic blank required.

Potentiated Pain Relief

WINTHROP LABORATORIES
New York 18, N. Y. • Windsor, Ont.

Demerol (brand of meperidine),
trademark reg. U.S. Pat. Off.



essential ally of the doctor
in relieving anxiety, tension

Trilafon®

perphenazine

an "agent of choice in treating tension and anxiety"[1]

- effective without somnolence
- allows the patient to continue his normal activities

TRILAFON Tablets—2 mg. and 4 mg.; bottles of 50 and 500.

TRILAFON REPETABS,® 4 mg. for *prompt effect* in the outer layer and 4 mg. for *prolonged action* in the timed-action inner core; bottles of 30 and 100.

For complete details on TRILAFON consult Schering literature.

(1) Marangoni, B. A.: Am. Pract. & Digest Treat. *8*:1959, 1957.

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TR-J-2698

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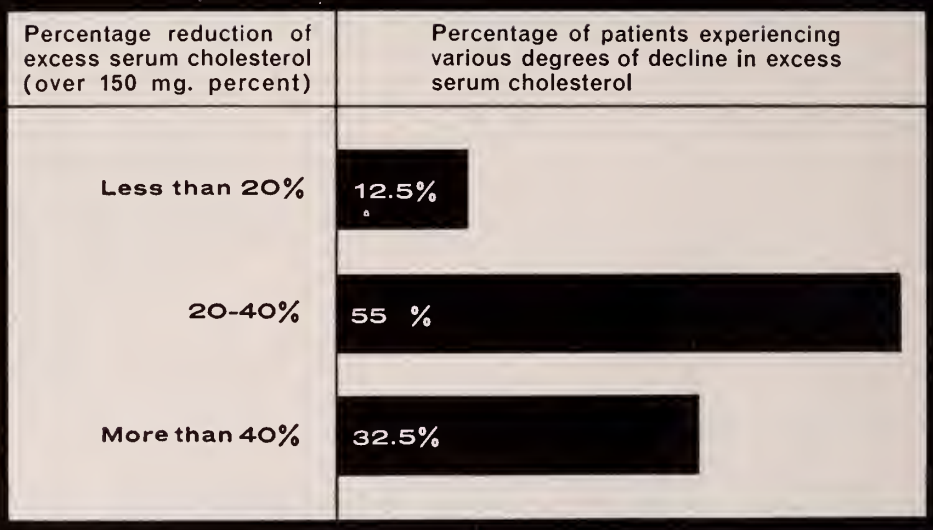
CYTELLIN* REDUCES HYPERCHOLESTEREMIA



. . . without the necessity of dietary restrictions

'Cytellin' provides the most rational and practical therapy available. Without any dietary adjustments, it lowers elevated serum cholesterol concentrations in most patients.

In a number of studies, every patient who co-operated obtained good results from 'Cytellin' therapy. On the average, a 34 percent reduction of excess serum cholesterol (over 150 mg. percent) has been experienced.

In addition to lowering hypercholesteremia, 'Cytellin' has been reported to effect reductions in C/P ratio, S_f10-100 and S_f12-400 lipoproteins, "atherogenic index," beta lipoproteins, and total lipids.

May we send more complete information and bibliography?

*'Cytellin' (Sitosterols, Lilly)

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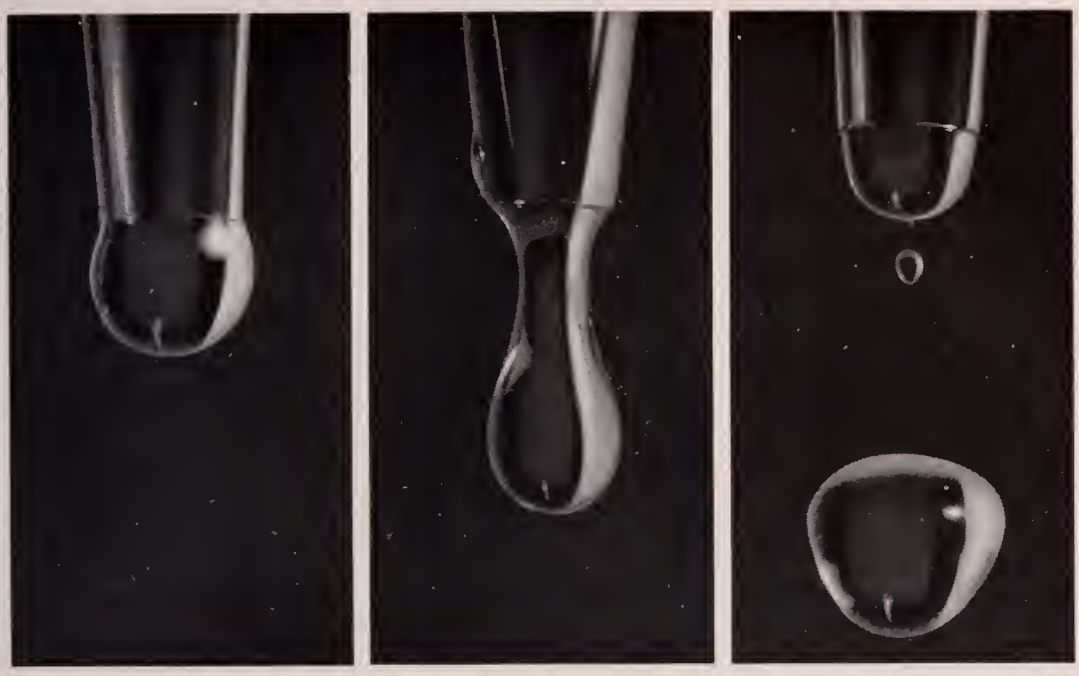

In Biliary Distress

ZANCHOL®

Improves Flow and Color of Bile

Zanchol (brand of florantyrone), a distinct chemical entity unrelated to the bile salts, provides the medical profession with a new and potent hydrocholeretic for treating disorders of the biliary tract.

The high degree of therapeutic activity of this new compound and its negligible side reactions yield distinct clinical advantages.

- Zanchol produces a bile low in sediment.
- Zanchol enhances the abstergent quality of bile.
- Zanchol produces a deep, brilliant green bile, regardless of its original color, suggesting improved hepatic function.
- Zanchol improves the flow and quantity of bile without increasing total bile solids.

Bile with these qualities minimizes biliary stasis, reduces sediment and debris in the bile ducts and discourages the ascent of infection.

For these reasons ZANCHOL has shown itself to be a highly valuable agent in chronic cholecystitis, cholangitis and care of patients following cholecystectomy.

Administration: One tablet three or four times a day. Zanchol is supplied in tablets of 250 mg. each. G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

SEARLE

Section on Medical History

It may be that Dr. Mary Sorenson, who practiced during the nineteenth century in Racine, Osceola and Milltown, was the first woman to bob her hair in this country. It happened this way:

During an extremely busy period of her practice, she broke her arm. She found it impossible to "put up" her hair, and the short hair was a time-saver when she was called to a sick bed in a hurry. Historians say no other woman, in Wisconsin at least, wore her hair as did Doctor Mary during her era.

Dr. Sorenson is shown with her husband, daughter Elnora and son Seward, before the turn of the century. The picture was taken during a trip to Chicago.

But she was used to being different. Lady doctors were almost unheard of in the 1880's, and she had to strive doubly hard to win the respect and admiration of her colleagues and patients. But this she did; her ability and fitness for the hardships of her profession were not to be hidden.

She was born in Denmark in 1837, and came to Chicago in 1859. From childhood on, she had dreamed of a career in medicine, but her hopes were almost forgotten when she was married in 1863 and started a family. Although she had four youngsters to care for, she decided to enroll in Hahnemann College in Chicago. Several years of sacrifice and hardship followed before she took home her degree.

During the next decade, she practiced in Chicago, Racine, Tacoma and Osceola, finally settling in Milltown (then Patterson). There her success attracted attention, and she was called to all parts of Polk County to provide medical care. For several years Doctor Mary was county physician.

Two sons attempted to follow in her footsteps. But Martin died during his senior year in medical school, and Seward died of tuberculosis after several years of practice.

Doctor Mary's life story in medicine was quite similar to that of other pioneer physicians. Some nights she bedded down in Indian villages; some years there were epidemics which kept her busy for weeks; and always there was the problem of transportation over sparsely settled country.

Often her compensation came in cord wood and furs; she would accept nothing from those folks she knew were unable to pay.

Doctor Mary practiced until she was 65, but she remained active and keenly interested in community affairs until her death in 1924.

It was said that she was most proud of the fact she was a direct descendant of Hans Vitus Bering who discovered the sea and strait near Alaska which bear his name.

Her granddaughter, Mrs. Carl Sorenson, is a teacher at the Cushing School, St. Croix Falls. On several occasions she has arranged exhibits of her grandmother's medical instruments for the pupils, some of which are as bright and shiny as when they were purchased more than 80 years ago.

* * *

The State Historical Society reported recently it received a desk once used by Dr. Nicholas Senn, who practiced in Fond du Lac and Milwaukee before the turn of the century and served a year as A.M.A. president. Dr. G. A. Hausman, of Seattle, whose father was a student of Dr. Senn, donated the desk through Mrs. L. T. Donavan of Waupun. The desk has already been transported to the Medical Museum of Wisconsin building at Prairie du Chien.

* * *

WANTED: Contributions for this page from readers. Your contributions would assure a continuous flow of material on medical history. Take a few minutes' time tonight and jot down one or more interesting stories you know, people and places in medical history, events that show early medicine in Wisconsin. Send us early photographs, too, if they are available.

WHEN YOU TREAT INFECTIONS IN PATIENTS SUCH AS THESE

- debilitated
- elderly
- diabetics
- infants, especially prematures
- those on corticoids
- those who developed moniliasis on previous broad-spectrum therapy
- those on prolonged and/or high antibiotic dosage
- women—especially if pregnant or diabetic

the best broad-spectrum antibiotic to use is

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Squibb Tetracycline Phosphate Complex (Sumycin) and Nystatin (Mycostatin) — Sumycin plus Mycostatin

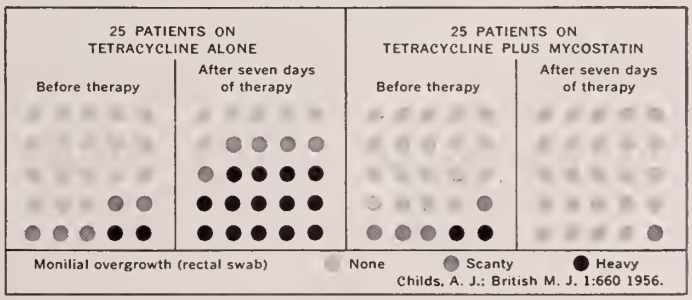
for practical purposes, Mysteclin-V is sodium-free

for "built-in" safety, Mysteclin-V combines:

1. Tetracycline phosphate complex (Sumycin) for superior initial tetracycline blood levels, assuring fast transport of adequate tetracycline to the infection site.

2. Mycostatin—the first safe antifungal antibiotic—for its specific antimonilial activity. Mycostatin protects many patients (see above) who are particularly prone to monilial complications when on broad-spectrum therapy.

MYSTECLIN-V PREVENTS MONILIAL OVERGROWTH



Childs, A. J.: British M. J. 1:660 1956.

Capsules (250 mg./250,000 u.), bottles of 16 and 100. *Half-Strength Capsules* (125 mg./125,000 u.), bottles of 16 and 100. *Suspension* (125 mg./125,000 u.), 2 oz. bottles. *Pediatric Drops* (100 mg./100,000 u.), 10 cc. dropper bottles.

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FOR LEG FATIGUE AND MILD VARICOSITIES

Recent clinical research demonstrated the excellent value of Supp-hose for leg fatigue, and mild disorders where heavy surgical stockings are not prescribed. The advantage of Supp-hose is that it looks just like any sheer nylon stocking, thus it overcomes one of the main objections of the patient concerned about her appearance.

SO MANY WOMEN COMPLAIN ABOUT LEG FATIGUE!

As you know, expectant mothers, housewives, working women, and women with mild varicosities all complain about discomfort of the extremities. Supp-hose eases this leg fatigue and gives gentle support all day long. Yet Supp-hose contains no rubber! Every stitch is fine nylon with a special twist that provides an elastic quality.

A VERY ECONOMICAL STOCKING!

Patented Supp-hose costs a woman just one-third what she usually pays for heavier surgical stockings. And wear tests indicate Supp-hose should give five times the wear of ordinary nylons. Supp-hose is available in proportioned sizes in beige, natural and white. At drug and department stores.

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THE MEDICAL FORUM

ATTEND ATHLETIC INJURIES CONFERENCE NOV. 7!

Chiro Resolutions Soundly Rejected At American Legion Conventions

MADISON—Chiropractic resolutions, seeking inroads in care at Veterans Administration facilities, were soundly whipped at state and national American Legion conventions late this summer.

Resolutions offered by posts in Coleman, Fennimore, Prairie du Chien and Racine never reached the floor at the state meeting in La Crosse. Introduced late in the national session at Chicago, the proposals met defeat by a 20 to 1 margin.

Robert G. Wilke, Milwaukee, state department adjutant, said the resolutions were "more or less bypassed at La Crosse, and no definite action was taken one way or another. . . Instead the resolutions were referred to the department commander in that he appoint a committee to make a further study."

Wilke added:

"Due to the proximity of the national convention, it was impossible for any committee to get together, and so in Chicago, the Wisconsin delegation cast its vote 76–6 against the chiropractic resolutions."

Two proposals relating to chiropractic came before the legionnaires at Chicago.

One, introduced by Colorado members, asked for the legion to sponsor and support legislation to the end that **"whenever any person is entitled by law or regulation to receive medical care by or through the VA, he shall, at his own election, have the right to receive chiropractic care, and the VA shall make the services of a qualified chiropractor available to such veteran on an out-patient basis."**

Identical resolutions were brought in by 15 other states, but were set aside because Colorado's was first in line.

The second proposal, offered by Oregon legionnaires, recommended that the legion's National Rehabilitation Commission **"be directed to use every effort and means necessary to the end that qualified chiropractic service be provided by the VA, on an out-patient basis, for those disabled veterans who are eligible for, and desirous of, such service, in those states whose requirements for chiropractic licensure include two academic years of pre-professional education at the college level, and four years of professional education, with a minimum of 4,000 hours."**

It also stated that "many disabled comrades have found relief and have made additional improvement under chiropractic care, and . . . that it should be the purpose of the legion to provide the benefits of modern healing science."

The state resolutions had similar wording.

Mr. Reynolds

REYNOLDS JOINS S.M.S. STAFF

MADISON—David C. Reynolds, former administrator of Madison General Hospital, has joined the State Medical Society staff as administrator of hospital services.

Reynolds will supervise the hospital portion of Wisconsin Physicians Service.

The new staff member is a native of Madison and a graduate of St. Mary's University, San Antonio, Tex. He earned his master's degree at Washington University in St. Louis.

Foundation Sponsor Of Long-Sought Injuries Session

MADISON—Wisconsin physicians, particularly those treating high school athletes, are invited to attend the Conference on Athletic Injuries in Milwaukee Nov. 7.

A project of the State Medical Society's Charitable, Educational and Scientific Foundation, the meeting will stress ways and means of preventing and treating injuries to prep athletes more effectively. It will be held at The Electric Co. auditorium, 231 West Michigan, and begin at 9 a. m.

The conference faculty includes seven Wisconsin physicians, including the foundation president, Dr. W. D. Stovall of Madison. Other participants will include:

Dr. Lloyd M. Simonson, Sheboygan, chairman of the society's Division on School Health; **Dr. Frank D. Bernard and Dr. Edgar S. Gordon**, Madison; **Dr. Francis J. Millen**, Milwaukee; **Dr. D. W. McCormick**, Fond du Lac and **Dr. Robert Krohn**, Black River Falls.

Dr. Stephen E. Reid, Evanston, Ill., physician to Northwestern University athletic teams, will speak on "Knee and Ankle Injuries."

Joseph P. Dolan, Ph. D., Kirksville, of North East Missouri State College, will present a discussion and demonstration on "Taping and Physical Therapy."

Speakers will present authentic material on head and facial injuries, emotions, heart, hernia, growth, fatigue, conditioning and other pertinent subjects. In addition to the physicians, Coaches Ole Jorgensen, Neenah; Charles Jaskwhich, Kenosha; Phil Manders, Milwaukee, and School Supt. Fred Holt, West Bend, will comprise the faculty.

Physicians in attendance will receive, upon request, six hours of Category II, American Academy of General Practice credit.

Mr. John E. Roberts, Stevens Point, executive secretary of the

(Continued on page 38)

MDS URGED TO WORK WITH CORONERS ON AUTOPSIES

MADISON—Let's say the widow Brown died suddenly under circumstances that indicated a post-mortem examinaiton . . .

At her death she was attended by her family physician, and her neighbor, a woman of her own age.

The widow had no known relatives.

Who, under Wisconsin law, can authorize an autopsy?

The statutes read as follows:

"155.05 Post Mortem examinations. Consent for a licensed physician to conduct this examination of the body of a deceased person shall be deemed sufficient when given by whichever one of the following assumes custody of the body for purposes of burial: father, mother, husband, wife, child, guardian, next of kin, or in the absence of any of the foregoing, a friend, or a person charged by law with the responsibility for burial. If two or more such persons assume custody of the body, the consent of one of them shall be deemed sufficient."

After the death of a patient, her right to freedom from interference automatically passes in a modified form to her spouse or to her next of kin, and any unauthorized interference with her dead body exposes the offender to a suit for damages by the person entitled to its custody. One who participates in an examination to which the surviving spouse of next of kin has not consented and which is not authorized by law is also subject to criminal prosecution.

Generally, the person entitled to possession of a body for purposes of burial is entitled to approve a post-mortem examination upon it to determine the cause of death. The right to the body, and the attendant right to give or withhold consent to an examination, does not vest in the executor.

The neighbor said the widow had asked her to help make burial arrangements, "when her time came." The widow left no will, no directions that an autopsy should be performed on her body.

The physician called the coroner who, in all jurisdictions, has legal authority to perform autopsies with respect to deaths due to other than natural causes.

When death is due to violence or casualty or there is reasonable

(Continued on page 38)

U. W. Medical Student Serves At Bethesda

WASHINGTON, D. C.—Russell N. Sacco, Kenosha, Wis., who attends the University of Wisconsin Medical School, was one of 135 students who participated in the Commissioned Officer Student Training and Extern Program during the past summer.

He was assigned to the National Institute of Neurological Diseases and Blindness, National Institutes of Health, Bethesda, Md.

The program is a project of the U. S. Department of Health, Education and Welfare, and was arranged to stimulate the interest of promising students in public health service careers, to enable them to further professional knowledge while gainfully employed, and to provide the government with competent help during vacation months.

Assignments under the program are given to medical, dental science, engineering, nurse and veterinary students in 120 approved schools.

ASSISTANTS TO MEET IN CHICAGO

CHICAGO—Dr. Robert J. Samp, University Hospitals, Madison, and Mr. Harold E. Scherer, administrator, Monroe Clinic, will take prominent roles in the third annual meeting of the American Association of Medical Assistants here Oct. 31–Nov. 1–2.

Dr. Samp, who serves as director of the hospitals' tumor clinic, will preside as master of ceremonies for the group's banquet and installation of officers.

Mr. Scherer will address the general session, speaking on the subject "Live, Learn and Dream," related to pertinent public relations practices for the assistant in the physician's office.

Miss Lois Pluckhan, Madison, former president of the Wisconsin State Medical Assistants' Society, was nominated as a candidate for the national office of recording secretary. She is chairman of the 1958 A. A. M. A. program committee.

Patient Sues Kenosha Chiro

KENOSHA—A Kenosha couple is seeking $25,000 in a suit directed against a Kenosha chiropractor, alleging he vibrated her vertebrae so vigorously that he broke three of her ribs.

The suit was filed recently in Kenosha County circuit court.

Mr. and Mrs. Julius Cluckey charged in their suit that Robert L. Grayson had pushed too hard while treating Mrs. Cluckey, 61, for a back ailment on Dec. 20, 1957. She seeks $15,000 to cover her alleged injuries and her husband is asking $10,000 for medical and hospital costs and loss of companionship.

Grayson declined to comment on the charges. He currently is involved in litigation with the state. The attorney general's office is seeking an injunction to prevent him from using treatment methods it contends are not prescribed by state law, and from using the title of doctor.

Grayson acknowledged that he uses machines in treating arthritics and heart patients. He also said he has treated patients with ulcers and others suffering from communicable diseases.

CHIROS THREATEN SUITS VS. FOES

NEW YORK CITY—The Chiropractic Association of New York recently concluded its annual convention with a resolution **"to bring a $1,000,000 action against medical groups accused of conducting drives to deny licensing and regulating legislation to chiropractors."**

The association also called for an order to halt "undercover medical lobbying" in the next legislative session in Albany.

At the same time, the president of the chiropractic association's New York metropolitan district reported that the State of New York had become a "dumping ground" for chiropractors from states with stiff licensing qualifications.

New York is one of the three states in the nation which does not license chiropractors.

PIONEER RADIO SCRIPTS PRESENTED TO STATE HISTORICAL SOCIETY

MADISON—Back in 1931 Dr. William W. Bauer began a pioneer experiment in the use of mass communications to bring health education service to a community.

It was a trail-blazing program, "Radio Health Episodes," broadcast over WRJN, Racine, and now recognized as an outstanding forerunner in public service broadcasting.

Milwaukee-born Dr. Bauer, a graduate of the University of Wisconsin, was Racine's health commissioner at that time. His radio features, the first of their kind, were produced on a slim budget, but were plump with ideas, ingenuity, wit, and a down-to-earth approach to current medical problems.

Dr. Bauer

These historic scripts, through the good offices of Dr. Bauer and the A. M. A., are now part of a valuable collection of material presented recently to the Mass Communications History Center at the State Historical Society of Wisconsin. The center, newly-organized, collects preserves and makes available to scholarship basic materials from all phases of mass media—the press, radio, television, public relations and the movies.

The scripts are only a small part of the total Bauer-A. M. A. contribution. They are regarded, however, as extremely treasured milestones in the acceptance of public service programming, from radio's point of view, and in the advancement of public health responsibility, from the medical profession's point of view.

The WRJN series reflects the spadework that was necessary to persuade the community of the value of immunization, the importance of periodic checkups and x-rays, the dangers of quackery, the need for proper care of pregnant women, infants and children, and more.

Since 1932 Dr. Bauer has been director of the A. M. A. Bureau of Health Education and a leader in the use of radio and TV for health education and information.

His other contributions to the center include scripts, discs, transcriptions, films, film clips and pictures of early A. M. A. programs.

Offer Disaster Plan Film—Write S. M. S.

MADISON—"Disaster Plan," a 17-minute, 16–mm film showing how a community and a hospital are able to spring into action to care for disaster victims, is now available.

Described as excellent for civil defense meetings, and gatherings of physicians or hospital staff members, the film was based on procedures of the American Hospital Association, as set forth in the booklet, *"Principles of Disaster Planning for Hospitals."*

The film may be obtained by writing the State Medical Society, Box 1109, Madison 1. Due to unusual demand, the film should be booked eight weeks or more in advance.

Five Take Pre-Med Study at Northland

ASHLAND—Four Ashland physicians took their undergraduate study at Northland College in this city.

Before going on to other schools to take their M.D. degrees, Drs. Bruce C. Prentice, Harry H. Larson, Howard V. Sandin and George W. Harrison attended Northland, one of the oldest educational institutions in Wisconsin.

Dr. Farrell F. Golden, Madison, also took pre-med courses at Northland.

This information was provided by J. T. Kendrigan, director of placement at the college.

SEEK DATA ON MEDICAL CARE FOR PLANT WORKERS

CHICAGO — Medical societies and physicians are invited to send to the A.M.A. information on their activities in the field of medical care for industrial workers.

The A.M.A. Committee on Medical Care for Industrial Workers currently is working on a "Guide for Measuring Work Absence Due to Illness and Injury." Information is sought to supplement field surveys, and may be sent to the A.M.A. or to the State Medical Society of Wisconsin, Madison 1.

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MILWAUKEE WISCONSIN

Farmers Sign for Health Insurance

NEW YORK—The Wisconsin farmer is rapidly catching up with the city dweller in the amount of money he spends to protect his health.

The Health Insurance Institute reported this fall that the average farmer in the midwest spent $48 on voluntary health insurance in 1955, compared with an average of $15 in 1941. The urban resident's average was $81 in 1955.

The farmer also spent $193 in 1955 for direct medical care expenditures, including $61 to physicians and surgeons; $27 to hospitals, $37 for medicines and drugs, and $30 for dental attention.

Fifty-six per cent of Wisconsin farm families carried some form of health insurance. Broken down by incomes, 37 per cent with incomes less than $1,000 annually had health insurance. The percentage tended to rise steadily as income increased. The top income bracket in the survey, $7,500 and over, had 73 per cent of its families covered.

The most recent estimate (summer, 1958) placed the number of persons in Wisconsin covered by health insurance at a new record high, 2,794,000. The total was 2,592,000 on Dec. 31, 1956.

ON THE S.M.S. CALENDAR

OCTOBER

30—Postgraduate Circuit Teaching Program, Madison

NOVEMBER

5—Claims Committee, S.M.S.
7—Conference on Athletic Injuries, Milwaukee
10—Interstate meeting, Cleveland, Ohio
20—Postgraduate Circuit Teaching Program, Stevens Point

DECEMBER

3—Claims Committee, S.M.S.

Gundersen to Speak On Civil Defense

CHICAGO—Dr. Gunnar Gundersen, La Crosse, Wis., president of the A. M. A., will speak at the ninth annual A. M. A. County Medical Societies' Civil Defense Conference in Chicago Nov. 8–9. His subject will be "The Profession's Responsibilities in Civil Defense."

NEW VISUAL AIDS NOW AVAILABLE

CHICAGO—Here are two new A. M. A. visual aids, excellent for public relations purposes and suitable for both medical and lay audiences:

"Whitehall 4-1500"—a 30-minute, sound, color film explaining doctors' services to the public, not just as individual MD's, but as members of medical organizations. It answers questions like the following: who assures high hospital standards? are doctors doing anything to reduce traffic accidents? what do doctors do to improve our children's health?

"Mechanical Quackery"—a 16-minute, 35 mm. sound, color slidefilm. Depicts numerous quack devices. In a style suitable for all age groups, it informs the public of the dangers involved.

Both aids were planned for service clubs, schools, medical societies, women's groups and allied organizations. There is no charge for the films, available through the A. M. A., 535 North Dearborn St., Chicago 10, or the State Medical Society of Wisconsin, Box 1109, Madison 1.

LIST CHANGES IN MEDICARE

WASHINGTON, D. C.—Major changes in eligibility, coverage and procedures in the Medicare program were started Oct. 1 by the Office for Dependents' Medical Care.

Representatives of that office and the Department of Defense outlined the following restrictions:

Spouses and children of active duty personnel will no longer be entitled to the following types of treatment except through military medical facilities:

a) Injuries or illnesses which are not directly related to a period of hospitalization.
b) Pre and post surgical tests before and after hospitalization.
c) Neo-natal visits.
d) Termination visits (those instances where one physician sees a patient initially and transfers her to the care of another M. D. at the time of hospitalization).
e) Treatment of nervous and mental diseases.
f) Elective surgery.

The extent to which obstetrical and maternity care is to be paid in civilian facilities rendered by civilian physicians was determined as follows:

a) For those dependents who are residing apart from their sponsors, they may elect (subject to above exclusions) to receive authorized care from civilian sources.
b) For those dependents residing with their sponsors, these restrictions may be imposed: If the dependent is in the second or third trimester and if the dependent has been receiving pre-natal care from a civilian physician, the dependent may continue to receive the care provided there is no change of (1) physicians, or (2) duty station of the sponsor.

Dependents who reside with their sponsors will be required to clear with the appropriate authority at the nearest uniformed medical service facility as to whether the desired authorized care is available at that facility. If it is available, the dependent will be required to get care at the military installation. If it is not, or if the facility is already operating at optimum, the dependent may receive a certificate authorizing private care through civilian facilities at government expense and such certificate will be necessary in addition to the I. D. Card.

Provisions for treatment of acute medical conditions remain essentially unchanged. However, admissions for patients not acutely ill for diagnostic surveys are not payable.

KENOSHA SOCIETY STARTS POISON CONTROL CENTER

KENOSHA—The Kenosha County Medical Society has established a poison information center "to make Kenosha a safer place to live."

Located at the Kenosha Hospital, the center is the result of many weeks of effort by a special commtitee, headed by **Dr. David W. Davis.** Other committee members:

Drs. R. G. Welsch, Fredrick Wood jr., Louis H. Creighton and David N. Goldstein. City Health Director. **Dr. James Altman** is an ex officio member.

A staff of consultants for the center is almost completed, and includes James W. Watts and J. W. Merrick, veterinarians; Stanley Kedzierski and Michael Gallo, pharmacists, and a botanist from the Wisconsin Extension Division.

"Now any area doctor can learn the contents of any material accidently swallowed by a child," Dr. Davis said. "Knowing the poison is essential for proper treatment, and prompt treatment often means the difference between life and death. Now this information is only a phone call away, "and Kenosha should be a safer place to live."

Core of the information center is a set of file cards, books, manuals, monographs and bulletins containing almost all known poison substances, along with pertinent data about antidotes. New information is arriving daily from the National Clearing House for Poison Control Centers, an agency of the U. S. Department of Health, Education and Welfare, and other agencies.

The society said the Kenosha Pharmacy Association has cooperated closely in establishing the center, and donated reference material for the study of poison cases.

Dr. Davis, saying that accidents are the major cause of death in children between one and 15, reminded parents to be alert to the possibility of accidental poisoning, to keep such preparations out of reach, and to discard old drugs whenever possible. He urged parents to call a physician at once if poisoning is suspected, to save the preparation, to remember when it was consumed, and how much.

Other centers were established during the past year in Madison and Milwaukee.

Business Guide To Be Distributed

MADISON—The State Medical Society has offered to help distribute a new guidebook, "The Business Side of Medical Practice," to senior medical students and others during the coming year.

The A. M. A. joined with the Sears–Roebuck Foundation in preparation of the publication. It contains information designed to help physicians make their own decisions on the business side of medical practice and to put them on the track of other sources of information.

It has been estimated that the society will distribute approximately 200 books this fall to seniors at Marquette and Wisconsin medical schools. Distribution to interns and residents will be handled by the A. M. A.

The society said it would like to make the guidebook available to all physicians seeking licensure in Wisconsin and who evidence some interest in practicing here.

Dr. F. J. L. Blasingame, general manager of the A. M. A., said there was a time when a doctor setting up practice merely hung up his shingle, got some instruments and an office, some medications and a horse, and then kept his bookkeeping in his head or a little black book. Now, he said, the practice of medicine is a complicated matter, requiring much study.

The guidebook stresses these subjects: practical problems of setting up practice, selecting the place to practice, clearing legal hurdles and securing professional assistance, locating the office, financing the establishment of an office, insurance, mechanics of providing good medical service, running the business of a practice, billing and collecting.

HEALTH CARE COSTS RISING TOO FAST?

CHICAGO—The fear that increasing health care costs may price health insurance out of reach of the public was expressed recently by Morton D. Miller, chairman of the Health Insurance Council.

Rising costs, he said, is one of two major problems now facing voluntary health insurance, the other being extension of coverage for senior citizens.

Miller, also second vice president of the Equitable Life Assurance Society of the United States, said:

"By far, these increased costs have meant better medical care, leading to better health for all. On the other hand, there is little question but that some of the increased costs are unnecessary and that better future planning would help to stabilize costs.

"These unnecessary costs, whether arising from abuse or ineffective use of existing medical services and facilities, must be eliminated. Health insurers and the medical care professions must unite their efforts to justify these increases in the cost of health care and in the cost of health insurance, which are in the public interest."

It is the doctor, directing the care of the patient, who determines the quality and to a large extent the quantity of the patient's medical care, Miller said. It is he, the speaker added, who controls to a significant degree the way in which health insurance as a means of financing health care works out.

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Business Consultants to the Medical Profession.

Inquiries Invited

BLUE CROSS-TYPE INSURANCE BOUGHT BY MANY BRITONS

LONDON—(UP)—Even in this land of socialized medicine a Blue Cross-type hospital insurance scheme is thriving.

Britons, it seems, like that little something extra which they can't get for their $1.40 a week average National Health Service subscription.

The British United Provident Association, a non-profit organization, has been supplementing the NHS for more than 10 years.

Right now, a spokesman said, more than 700,000 Britons are enjoying its benefits, and more are coming in each month, mostly under group plans launched by their employers.

FIXED WEEKLY CHARGE

Under NHS, set up by the 1948 Labor government, Britons get free care in hospitals, free treatment from doctors and free medicine—free, that is, except for the 14-cent fee on each prescription and the fixed weekly charge deducted from their salary.

Such a system appears to leave little room for a Blue Cross-type of organization. But the BUPA, surprisingly, has more clients than it can handle.

"Many people don't feel that socialized medicine, with everyone on the same level, gives them the same benefits they got from their own private doctors before the war," said Herbert Cooper, BUPA spokesman.

SOMETHING EXTRA

"They want the same personalized care they used to get—and they're willing to pay for it. Membership in BUPA gives them private care without the expense of calling in a private doctor who isn't in the national health service," he added.

A member of BUPA who gets sick goes to his NHS doctor in the normal way. The doctor examines him, and if hospital treatment is required sends him either to a BUPA-owned hospital or to a private room in a state-owned hospital. BUPA picks up and tabs not exceeding $86 a week. BUPA doesn't have many of its own doctors, although it does retain one or two to treat members who don't regularly go to a state doctor.

BUPA does not come in conflict with the government departments which run the NHS.

"Everyone can still have free treatmnet if he wants," Cooper said. "BUPA is something extra—you might call it the inexpensive sauce with the free steak."

EDITOR'S NOTE

This article, prepared by United Press, appeared in the *Kenosha News* last spring.

NAME PICARD TO HEAD G. P. GROUP

MILWAUKEE—Dr. Charles J. Picard, Superior, was named president-elect of the Wisconsin Academy of General Practice at the group's annual meeting here in September.

Dr. David N. Goldstein, Kenosha, took office as president, succeeding Dr. T. J. Nereim of Madison.

Other officers elected were Dr. Cyrus G. Reznichek, Madison, speaker of the congress of delegates; Dr. John A. Keible, Milwaukee, secretary-treasurer; and Drs. A. H. Stahmer, Wausau; James J. Leahy, Park Falls, and Joseph S. Devitt, Milwaukee, directors.

MADISON—A marker at the base of a hard maple tree presented to the State Medical Society by Dr. H. E. Kasten, Beloit, during his term as president, won the admiration of five members of the society's Council recently.

Viewing the addition to the headquarters grounds above are (from left): Dr. R. G. Arveson, Frederic, council president; Dr. L. O. Simenstad, Osceola; Dr. J. H. Houghton, Wisconsin Dells; Dr. A. H. Heidner, West Bend, and Dr. R. E. Galasinski, Milwaukee.

The marker is embedded in a granite-like rock found on the society grounds, near the lake shore. Its wording:

THE "KASTEN" TREE
Presented By
Harry E. Kasten, M. D., Beloit
102nd President
State Medical Society of Wisconsin
1957–1958

Dr. Kasten turned the gavel of office over to Dr. J. W. Fons, Milwaukee, last May, at the society's annual meeting. *(Rolf Lunde Photo)*

Loans for Medical Facilities Offered By Small Business Administration

MADISON — The Small Business Administration is continuing to make loans to nursing homes, privately-owned medical facilities and hospitals for expansion, improvements and general operations.

Its loans are of two types: participation loans, which are made jointly with banks and other private lending institutions, and direct loans, where no participation is available.

Recently the administration changed its definition of eligibility to the following:

Medical and Dental Laboratories—Those facilities which provide services to doctors, dentists, hospitals and similar health facilities, and are being operated for profit and with eligible proprietary hospital facilities of 100 beds or less.

Nursing Homes—Must not have an annual volume of receipts under $1,000,000.

Hospitals—Capacity of 100 beds or less.

The amount which the S. B. A. may lend is limited by law to a maximum of $250,000 to any one borrower. If a bank participates in the loan, however, the loan may be increased by the amount of the bank's participation. In any case, the total amount of the loan must be proportionate to the investment of the owners in the project.

An S. B. A. loan may be made for a period up to 10 years. Generally, the loans are made on an amortized repayment basis, usually with equal monthly installments. All or any part of the loan may be repaid, without penalty, before it is due, if the borrower so wishes.

For direct S. B. A. loans, the interest rate is six per cent. In loans in which the administration participates with a bank or other lending institution, the rate of interest may be fixed by the lending institution, but may not exceed six per cent. Interest is charged only on the actual amount borrowed from the government and for the actual time the money is outstanding.

Qualifying considerations include these requirements:

The applicant must show that the needed financing is not otherwise available on reasonable terms from another credit source.

The applicant must show that the loan can be repaid out of earnings.

The owners and operators of an applicant facility must be experienced in their field, must be competent and have sufficient professional training to operate the facility in accordance with accepted standards.

When licensing is required, the facility must have all such required by state, county or local agencies.

How to apply?

The applicant should first determine whether local lending institutions will extend the necessary financing, either alone or with S. B. A. Next, a loan application should be obtained from the nearest S. B. A. field office, completed and sent to that office and a copy sent to the private lender, if one participates.

The administration makes no charge for handling a loan application or for counseling an applicant on his financial problems. Full information is essential and availability of it will facilitate the application.

S. B. A. is the first peacetime independent federal government agency created for the sole purpose of advising and assisting the small business enterprises of the nation. It was created by act of Congress in 1953. In 1955 and 1956, Congress amended the S. B. A. Act to provide new and expanded authorities and responsibilites for the agency.

FOR INFORMATION—

Information and application blanks are available at Small Business Administration regional offices at Chicago, 226 West Jackson Blvd., and Minneapolis, Metropolitan Bldg., 2nd avenue at 3rd st.

A branch office is located at City-County Bldg., 210 Monona ave., Suite 313B, Madison 2, Wis. Telephone Alpine 6-2696. Robert M. Davis is the Madison office director.

Division Studies Handicapped Needs

MADISON—The State Medical Society's Division on Handicapped Children recently agreed to ask the Wisconsin Orthopaedic Society to study current needs around the state.

The group also asked the society to make recommendations relating to orthopaedic clinic programs, such as the 32 held in various Wisconsin communities during the past year.

URGENT NEED

Dr. J. W. Nellen, Green Bay, said a basic problem is that of medical education and the urgent need for more teaching material at the University of Wisconsin Medical School. He proposed that the Bureau of Handicapped Children, State Department of Public Instruction, meet with medical school authorities to determine ways to modify the clinic program in southern counties, and thus possibly improve the situation.

Drs. Newton Morton and **James Chung** presented a progress report on the muscular dystrophy research program at the Wisconsin Medical School, stressing the genetic phases of the study. A report on therapeutic trials is expected to be made sometime next year.

Dr. Morton said the treatment programs have not yet produced anything specific by way of benefit to the patient. Early recognition of muscular dystrophy via tests is not much more satisfactory than a close study by a good clinician, he said, adding that in the current research project, all representative types have been seen, except for the Duchenne type in females. This type is being sought for study.

TO SEEK AID

The genetic phase is expected to be completed early next year, by way of family follow-ups and detection of early cases.

Because current procedures of reporting have been quite ineffectual, **Dr. D. W. McCormick**, Fond du Lac, proposed that utilizing the records of hospitals might be a more effective means.

It was recommended to Dr. Morton that if further development of the program seems warranted, the hospitals be approached rather than the physicians in the state.

CONFERENCE . . .

(Continued from page 31)

Wisconsin Interscholastic Athletic Association, will serve as moderator of the afternoon session, Dr. Simonson will serve in this capacity during the morning meeting.

High school coaches, physical education teachers, principals and superintendents and athletic officials also have been invited to attend.

Cooperating agencies include the W. I. A. A., the Wisconsin State High School Coaches' Association, Wisconsin Academy of General Practice, State Board of Health, State Department of Public Instruction, Wisconsin Heart Association and the Wisconsin Orthopaedic Society.

FOREIGN MEDICAL STUDENTS TAKE U. S. TESTS

CHICAGO—More than 1,130 graduates of foreign schools took the second American medical qualification examination of the Educational Council for Foreign Medical Graduates in late September.

The council, with headquarters in Evanston, Ill., was founded in 1957 to aid graduates of foreign medical schools establish their qualification to assume internships or residencies in this country. Sponsoring agencies include the A. M. A., the Federation of State Medical Boards of the United States and the Association of American Medical Colleges.

The examination also was given in 59 other centers throughout the world. The candidates for the 7½ hour examination had their credentials approved by the council. The examination tests the candidates' knowledge of English as well as medicine.

Those passing the examination who enter this country on exchange visitor visas may participate in the National Intern Matching Program or may apply directly to a hospital for a residency or internship. Those entering on immigrant visas may be admitted to licensing examinations in at least 14 states, including Wisconsin.

Two American medical qualification examinations will be held in 1959, on Feb. 17 and Sept. 22.

Last March, a total of 298 candidates took the first examination, and 152 received a passing mark.

Team M.D. Vital Force in High School Athletics

UNIVERSITY, ALA. — The team physician plays a major role in protecting the health of the high school athlete.

That was the consensus of guests attending a conference on athletic injuries, held here recently under the sponsorship of the Medical Association of the State of Alabama.

(The State Medical Society of Wisconsin will conduct a conference on athletic Injuries in Milwaukee Nov. 7).

A statement outlining the team physician's responsibility, drafted by the Alabama society's Committee on Public Relations, was affirmed by those attending the recent session. It reads as follows:

1. Get to know players by attending squad meetings and practice sessions before the season begins.
2. Be present in the dressing room before games and at half time for an evaluation of injuries and to provide immediate care as indicated.
3. **Be responsible for determining whether an athlete may continue play.**
4. Accompany the coach on the field in case of injury during a game and decide what is to be done for the injured player.
5. Arrange for an emergency call system to assure needed medical service during practice sessions.
6. **Advise the coach on all medical matters.**
7. Inform the player's family at once in event of serious or potentially serious injury.

A.M.E.F. REPORTS NEW CONTRIBUTIONS

CHICAGO—The American Medical Education Foundation reported it had received contributions from Drs. Elston L. Belknap, Milwaukee; W. W. Grover, Bonduel; Gunnar Gundersen, La Crosse, and Robert A. Straughn, Madison.

AUTOPSIES . . .

(Continued from page 32)

ground for believing that it has been caused in that way, the right to custody of a dead body vests immediately in the coroner or the medical examiner. When the coroner or examiner has legal control of a dead body, his authority is supreme. He is entitled to the body in the condition in which it was at the moment of death.

Therefore, it is important that a physician should not undertake to perform an examination without the consent of the coroner or examiner in any case in which the body is properly within the jurisdiction of such officer, even though the surviving spouse or next of kin may have consented.

It is equally important for the doctor that he undertake no postmortem examination on the basis of authority from the coroner or examiner unless he is positive that the officer has jurisdiction over the body and power to authorize the autopsy.

Where this is doubtful, consent should also be obtained from the surviving spouse or next of kin.

A number of states (but not Wisconsin) have laws which provide that consent to an autopsy must be in writing. Although a non-written consent may be legally sufficient in some states, a physician should not perform an autopsy without first having obtained a specific written consent or authorization which he can produce as proof in the event of a subsequent challenge to his authority. As with consents to surgical operations, the consent to autopsy should be specific rather than general.

Although it has been held that a physician may legally perform an examination under consent obtained in his behalf by some other person, he may best protect himself by personally obtaining the consent from those authorized to give it.

In the case of the widow Brown, the physician and the coroner, in this instance also a physician, decided that an examination was called for. They asked for and received a consent in writing from her neighbor. There was no challenge to this procedure.

CONFERENCE ON ATHLETIC INJURIES

November 7, 1958
Electric Company Auditorium,
Milwaukee

For physicians, coaches, school administrators, physical-education teachers, athletic officials and parents. A project of the State Medical Society's Charitable, Educational and Scientific Foundation.

An outstanding faculty will discuss such subjects as Knee and Ankle Injuries, Head and Facial Injuries, Emotions, the Heart, Hernia, Conditioning, Fatigue, Growth, Taping and Physical Therapy.

A. A. G. P. credit for physicians attending.

Cooperating agencies include the Society's Division on School Health, the Wisconsin State High School Coaches' Association, the Wisconsin Interscholastic Athletic Association, the Wisconsin Academy of General Practice, Wisconsin Orthopedic Society, Wisconsin Heart Association, State Board of Health, State Department of Public Instruction.

NOW—is the time to make plans to attend!

ORTHOPEDIC APPLIANCES of every description since 1909. Certified Prothetic Mechanics and Fitters for Men and Women are your guarantee of careful, specialized cooperation.

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THE WISCONSIN PHYSICIANS' PHOTOGRAPHY CONTEST!

The contest, a project of the Charitable, Educational and Scientific Foundation, is open to all members of the State Medical Society. There is no entry fee, and each doctor may enter as many pictures as he desires.

Physicians are urged and invited to submit pictures they have taken in the following classes:

CLASS A—"Physicians at Work"
CLASS B—"Physicians in Research and Teaching"
CLASS C—"Physicians and History"
CLASS D—"Physicians in Public Service"
CLASS E—"Physicians at Play"

Entries will be received at the Society office after Feb. 15, 1959. Deadline: April 1. Pictures will be displayed at the Annual Meeting of the Society next May. Prizes will be awarded at the Annual Dinner. For contest rules: Write Box 1109, Madison 1.

Your participation will make this an outstanding exhibit!

Now—the most widely prescribed tranquilizer[1] in sustained release capsules

Meprospan*

meprobamate (Miltown®) capsules

q. 12 h.

Two capsules on arising **last all day**
Two capsules at bedtime **last all night**
relieve nervous tension on a *sustained* basis, without between-dose interruption

"The administration of meprobamate in sustained action form [Meprospan] produced a more uniform and sustained action . . . these capsules offer effectiveness at reduced dosage."[2]

Dosage: 2 Meprospan capsules q. 12 h.
Supplied: 200 mg. capsules, bottles of 30.

1. Meprobamate is more widely prescribed than any other tranquilizer. Source: Independent research organization; name on request.
2. Baird, H. W., III: A comparison of Meprospan (sustained action meprobamate capsule) with other tranquilizing and relaxing agents in children. Submitted for publication, 1958.

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A versatile, well-balanced formula for treating common upper respiratory infections, particularly during respiratory epidemics; when bacterial complications are observed or are likely; when patient's history is positive for recurrent otitic, pulmonary, nephritic, or rheumatic involvement.

CHECKS SYMPTOMS: Includes traditional components for rapid relief of the traditional nonspecific nasopharyngitis, symptoms of malaise, chilly sensations, inconstant low-grade fever, headache, muscular pain, pharyngeal and nasal discharge.

Available on prescription only.

Adult dosage for ACHROCIDIN Tablets and new caffeine-free ACHROCIDIN Syrup is two tablets or teaspoonfuls of syrup three or four times daily. Dosage for children according to weight and age.

TABLETS *(sugar coated)*

Each Tablet contains:

ACHROMYCIN® Tetracycline	125 mg.
Phenacetin	120 mg.
Caffeine	30 mg.
Salicylamide	150 mg.
Chlorothen Citrate	25 mg.

Bottles of 24 and 100.

SYRUP *(lemon-lime flavored)*

Each teaspoonful (5 cc.) contains:

ACHROMYCIN® Tetracycline equivalent to tetracycline HCl	125 mg.
Phenacetin	120 mg.
Salicylamide	150 mg.
Ascorbic Acid (C)	25 mg.
Pyrilamine Maleate	15 mg.
Methylparaben	4 mg.
Propylparaben	1 mg.

Bottle of 4 oz.

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SOCIETY PROCEEDINGS*

Green Lake–Waushara

Members of the Green Lake–Waushara County Medical Society met August 27 at the Whiting Hotel in Berlin to hear an address delivered by Dr. Tom DeKornfeld of Baltimore, Maryland. Doctor DeKornfeld, who was formerly from the University Hospitals in Madison, presented a movie on "Resuscitation Methods" and discussed the systems of mouth-to-mouth and mouth-to-airway resuscitation.

There were 24 members and their wives present.

Lafayette

The Lafayette County Medical Society met with their wives on June 24 for a dinner at the Pendarvis House in Mineral Point. Following a business meeting a Woman's Auxiliary was formed with the election of the following officers:

Mrs. N. A. McGreane—President

Mrs. D. J. Garland—Vice-president

Mrs. L. L. Olson—Secretary–treasurer

Pierce–St. Croix

On August 5 the Pierce–St. Croix County Medical Society met for dinner at the Steak House in Somerset.

Trempealeau–Jackson–Buffalo

Dr. Edward C. Voss, Jr., of La Crosse, was the guest lecturer at the July 29 meeting of the Trempealeau–Jackson–Buffalo County Medical Society. His speech was entitled "The Management of Patients with Advanced Carcinoma of the Breast."

During the business meeting *Dr. R. L. MacCornack, Jr.*, secretary-treasurer, gave notice of his resignation due to plans to move from the area. *Dr. John H. Noble*, Black River Falls, was elected unanimously to fill the position.

At the Tri-County Society's August 26 meeting held at Club Midway, Independence, Mr. Aspen Ede of Mondovi spoke to the group on the use of surgical and medical supports.

Two resolutions were introduced during the business meeting. The first was in support of the WPS insurance plan and the second resolved to publish an announcement in Trempealeau, Jackson and Buffalo counties backing WPS.

* Physicians whose names are printed in italics are members of the Society.

Wood

The Wood County Medical Society met August 21 at Casa Loma in Marshfield. The meeting consisted of the election of new members and a lengthy discussion on the insurance program in the state. Twenty-three members were present.

Southwestern Wisconsin Academy of General Practice

Dr. W. D. Hamlin of Mineral Point was elected president-elect of the Southwestern Wisconsin Academy of General Practice at its meeting held July 15 at the Dodge–Point Country Club. Other officers named were: *Drs. D. J. Garland*, president, and *L. E. Becher*, secretary-treasurer. Delegates chosen to attend the state convention were: Drs. Becher, Hamlin and *M. W. Randall*, with *Drs. N. G. Rasmussen, W. P. Hamilton* and *N. A. McGreane* selected to serve as alternates.

Chicago Diabetes Association

SECOND ANNUAL SYMPOSIUM ON DIABETES MELLITUS

at the

Drake Hotel, Chicago

MONDAY, NOVEMBER 17, 1958

Registration Fee: $25.00

Except members of Chicago Diabetes Assn., American Diabetes Assn., medical students, interns and residents, who may enroll without charge.

PROGRAM

Action of Insulin, by Rachmiel Levine, Univ. of Chicago; *Aspects of Pathology of Diabetes Mellitus*, by W. Stanley Hartroft, Washington Univ., St. Louis; *Recent Concepts in the Early Recognition of Diabetes Mellitus*, by Stefan S. Fajans, Univ. of Mich., Ann Arbor; *Management of the Ambulatory Diabetic*, by Arthur R. Colwell, Sr., Northwestern Univ., Chicago; *Management of Severe Diabetic Acidosis in Children*, by Jack Metcoff, NW Univ.; *Panel Discussion of Oral Hypoglycemic Agents*, moderator: Henry T. Ricketts, Univ. of Chicago Clinics; *Problems of the Pregnant Diabetic*, by Ralph A. Reis, NW Univ.; *Infants of Diabetic Mothers*, by David Yi-Yung Hsia, NW Univ.; *Insulin Antibodies*, by Joseph Skom, NW Univ.

WOODYATT MEMORIAL LECTURE: Francis D. W. Lukens, Prof. of Medicine and Director of the George S. Cox Medical Research Institute, Univ. of Pa., Philadelphia.

Inquiries should be addressed to: Chicago Diabetes Association, 5 S. Wabash Ave., Chicago 3, Ill.

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March 1958 Issue,
Pages 76 – 77.

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News Items and Personals*

Associates With Dr. Russell

A 1957 University of Wisconsin Medical School graduate, Dr. Henry W. Aufderhaar, recently joined *Dr. James C. Russell* in Fort Atkinson. He completed an internship at Madison General Hospital during the past summer.

Before entering the medical profession, Doctor Aufderhaar was associated with his brother for five years in the operation of a locker plant and packing plant at Clinton.

Dr. A. M. Hutter Lectures

"Some Concepts on the Needs of the Sick and Aging" was the subject chosen by *Dr. A. M. Hutter*, Fond du Lac, for a speech given at a graduation ceremony for practical nurses. In the talk he enumerated possible problems to be faced by those in the nursing profession and presented several methods of approach to these problems.

* Physicians whose names are printed in italics are members of the Society.

Dr. O. F. Guenther Retires

A Campbellsport physician, *Dr. O. F. Guenther*, has retired from practice after serving that community for over 30 years. Doctor Guenther taught school for a number of years before receiving his medical degree from Marquette University in 1926. Prior to locating in Campbellsport, he served a one-year internship at Milwaukee County Hospital.

In preparation for his retirement, Doctor and Mrs. Guenther have purchased a home in Oshkosh where their son, *Dr. V. G. Guenther* practices.

Doctor Leaves Plum City

Dr. Peter Foderick left Wisconsin to locate in Rochester, Minnesota. He had been in practice in Plum City for the past few years.

New Physician in Black River Falls

Announcement was made recently that Dr. Richard Holder joined the Krohn Clinic at Black River Falls. He arrived there from South Carolina.

NEW! TARCORTIN LOTION
excellent for lesions of head and hands
SUPPLIED: plastic squeeze bottles, ½ oz.

1. Welsh, A. L., and Ede, M.: J.A.M.A. *166*:158, 1958.
2. Bleiberg, J.: J.M. Soc. New Jersey *53*:37, 1956.
3. Abrams, B. P., and Shaw, C.: Clin. Med. *3*:839, 1956.
4. Bleiberg, J.: Am. Practitioner *8*:1404, 1957.
5. Clyman, S. G.: Postgrad. Med. *21*:309, 1957.

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Dr. Ahlbrand Locates in Wisconsin Rapids

It was announced in August that Dr. Roland C. Ahlbrand is practicing general medicine in Wisconsin Rapids in affiliation with *Drs. Wallace L. Nelson* and *John W. Schaller*. Doctor Ahlbrand's medical background consists of a degree from the Indiana University School of Medicine granted in 1955, an internship at Indiana University Medical Center, Indianapolis, and two years in the U. S. Army. While in the military service he received specialized training in pediatrics at Fort Benning, Georgia, and was stationed at the 20th Station Hospital in Nuremberg, Germany.

Dr. J. W. Hayden Takes New Position

Dr. John W. Hayden joined the Gundersen Clinic and the La Crosse Lutheran Hospital staffs to practice orthopedic surgery. For the past two years he was assistant to the professor of orthopedics at Harvard Medical School and chief of the orthopedic department at the Children's Hospital, Boston.

Doctor Hayden received his medical education at the University of New York, Syracuse, in 1947, served in the U.S. Navy for two years, took his residency in orthopedics in Boston at Children's, Massachusetts General, and Peter Bent Brigham Hospitals.

New Clinic Being Built in Argyle

In July ground was broken for a new clinic building at Argyle. The building will consist of a large reception room, business office, consultation room, two examining rooms, x-ray room, laboratory and drug rooms and other miscellaneous rooms. The one-story clinic will have a redwood finish and full basement. Its facilities will be used by *Dr. Richard Hunter* who has practiced in Argyle since 1954.

Dr. M. H. Olson Attends Conference

Among the 200 members of the United States Committee of the World Medical Association who were present at its third annual meeting was *Dr. Marvin H. Olson* of Wittenberg. During the meeting, which was held in San Francisco on June 24, Doctor Olson presented a stimulating report on the progress and program for the state membership chairmen.

Dr. Haines Practices in Green Bay

A general practitioner, Dr. Arthur W. Haines, opened an office in Green Bay during July. Doctor Haines graduated from the University of Michigan in 1957 and interned at the Toledo Hospital, Ohio, before coming to Green Bay.

HE NEEDN'T BE HIGH-STRUNG

WEIGHT REDUCTION: Obese patients may resist dieting because they fear losing the emotional security often involved in overeating. AMBAR helps them hold the diet line by giving them a more alert, brighter outlook. WITHOUT JITTERS: Methamphetamine, a potent CNS augmenter, produces less cardiovascular effect than amphetamine. In AMBAR it is combined with just enough phenobarbital to prevent overstimulation. AMBAR EXTENTABS provide 10-12 hours of appetite suppression in one controlled-release, extended-action tablet: methamphetamine hydrochloride, 10.0 mg.; phenobarbital (1 gr.) 64.8 mg. AMBAR TABLETS for conventional dosage or intermittent therapy contain methamphetamine hydrochloride, 3.33 mg.; phenobarbital (⅓ gr.) 21.6 mg. A. H. ROBINS COMPANY, INC., Richmond, Virginia, Ethical Pharmaceuticals of Merit Since 1878

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(METHAMPHETAMINE 15 mg., PHENOBARBITAL 1 gr.)
for patients who
require higher
methamphetamine
dosage

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Doctor Gettelman to Manage Whitehall Clinic

Dr. Sydney T. Gettelman took over management of the MacCornack Clinic at Whitehall on August 1, renting it from *Dr. R. L. MacCornack, Sr.*, who is retiring after practicing there for over 40 years.

Doctor Gettelman is a graduate of the University of Illinois Medical School. He took three years of residency training at the Milwaukee County Hospital where he specialized in internal medicine and diagnosis. Originally from Racine, Dr. Gettelman has been engaged in general practice. Doctor and Mrs. Gettelman and their six children moved to Whitehall the middle of September.

Dr. S. W. Simonson has returned to the clinic after a two-month absence. He had been associated with the clinic for 12 years. *Dr. Joseph Tschetter*, eye, ear, nose and throat specialist, has offices on the second floor of the clinic. Negotiations are underway to secure a resident surgeon to fill the vacancy left by *Dr. Robert L. MacCornack, Jr.*, who has taken a new position with a St. Paul, Minnesota, clinic. In the meantime, *Dr. Ralph F. Hudson* of Eau Claire, has been doing the surgical work.

Doctor Freeman Returns to Wausau

Dr. D. J. Freeman recently returned to Wausau to resume his medical practice with the Freeman Medical Group. For the past four years Doctor Freeman served a residency in internal medicine and cardiovascular diseases at the Wisconsin General Hospital in Madison.

Clinic Renamed

Members of the Shearer, Sumner, Falk Clinic have adopted the title "The Edgerton Clinic" for the name of their group. This was done in accordance with a growing policy of eliminating individual names for medical clinics.

Dr. Robert Krohn at Chicago Meeting

A meeting of the International College of Surgeons held in Chicago was attended by *Dr. Robert Krohn*, Black River Falls. The sessions were held during July.

Doctor Demke Sells Practice

In July *Dr. R. L. Demke* left Elroy for a location near Springfield, Illinois, after selling his practice to *Dr. M. E. Solberg*. Doctor Solberg had practiced in Milwaukee for the past nine years.

New Milprem®-200

a new potency for greater dosage flexibility in treating the **menopause**

new

Milprem-200

200 mg. MILTOWN®
+
0.4 mg. CONJUGATED ESTROGENS (EQUINE)

for prompt relief from emotional and somatic disturbances of ovarian decline

SUPPLIED: Bottles of 60 tablets.

DOSAGE: One tablet t.i.d. in 21-day courses with one week rest periods.
Should be adjusted to individual requirements.

ALSO AVAILABLE: Milprem-400 (400 mg. Miltown + 0.4 mg. Conjugated Estrogens, equine) in bottles of 60 tablets.

Literature and samples on request

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‡‡ TRADEMARK, REG. U. S. PAT. OFF. — THE UPJOHN BRAND OF CRYSTALLINE NOVOBIOCIN SODIUM

†† TRADEMARK

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Make new

Panalba*

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your broad-spectrum antibiotic of first resort

effective against more than 30 common pathogens, even including resistant staphylococci.

Available forms:

1. Panalba Capsules, bottles of 16 and 100 capsules. Each capsule contains:

Panmycin phosphate (tetracycline phosphate complex) equivalent to tetracycline hydrochloride . . . . . .250 mg.
Albamycin (as novobiocin sodium) . . .125 mg.

2. Panalba KM †† Flavored Granules. When sufficient water is added to fill the bottle, each teaspoonful (5 cc.) contains:

Panmycin (tetracycline) equivalent to tetracycline hydrochloride . . . . . .125 mg.
Albamycin (as novobiocin calcium) . .62.5 mg.
Potassium metaphosphate . . . .100 mg.

Dosage:

Panalba Capsules
Usual adult dosage is 2 capsules q.i.d.

Panalba KM Granules
For the treatment of moderately acute infections in infants and children, the recommended dosage is 1 teaspoonful per 15 to 20 lbs. of body weight per day, administered in 2 to 4 equal doses. Severe or prolonged infections require higher doses. Dosage for adults is 2 to 4 teaspoonfuls 3 or 4 times daily, depending on the type and severity of the infection.

to relieve edema of

DIURIL® "....

CHLOROTHIAZIDE

FINNERTY, F. A., Buchholz, J. H. and Tuckman, J.: J.A.M.A. **166**:141, Jan. 11, 1958.

DIURIL (Chlorothiazide) given alone to 85 patients, ". . . caused an excellent diuresis, with reduction of edema, weight, blood pressure, and albuminuria. . . . The average effective dose was found to be 1 Gm. per day by mouth. . . . The usually excellent response coupled with the absence of significant toxicity and lack of development of drug resistance makes chlorothiazide ideal for the prevention and treatment of toxemia."

DOSAGE: one or two 500 mg. tablets of DIURIL once or twice a day.

SUPPLIED: 250 mg. and 500 mg. scored tablets DIURIL (chlorothiazide); bottles of 100 and 1,000.

DIURIL is a trademark of Merck & Co., Inc.

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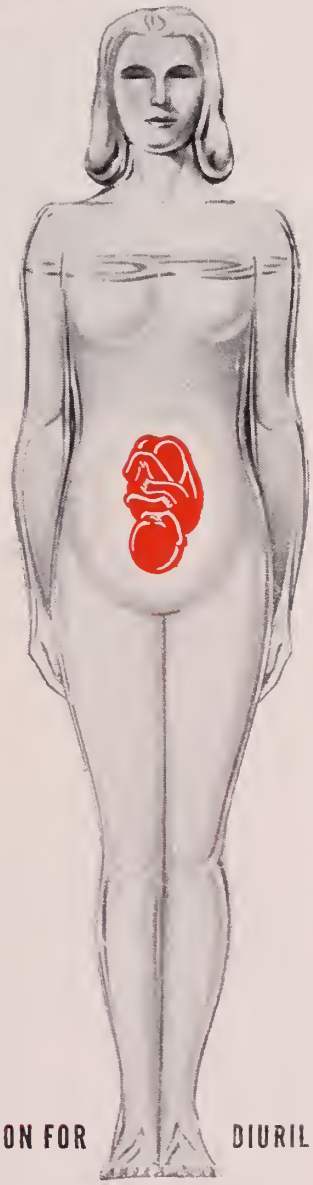
pregnancy



....caused an excellent diuresis, with reduction of edema, weight, blood pressure, and albuminuria...."

ANY INDICATION FOR DIURESIS IS AN INDICATION FOR DIURIL

"Much better

COSA-TETRACYN*

GLUCOSAMINE POTENTIATED TETRACYCLINE

CAPSULES
(black and white)
250 mg., 125 mg.

ORAL SUSPENSION
(orange-flavored)
125 mg. per tsp. (5 cc.), 2 oz. bottle

NEW! PEDIATRIC DROPS
(orange-flavored) 5 mg. per drop
calibrated dropper, 10 cc. bottle

COSA-TETRASTATIN*

glucosamine potentiated tetracycline with nystatin

antibacterial plus added protection against monilial superinfection

CAPSULES (black and pink) 250 mg. Cosa-Tetracyn, (with 250,000 u. nystatin)

ORAL SUSPENSION 125 mg. per tsp. (5 cc.) Cosa-Tetracyn, (with 125,000 u. nystatin), 2 oz. bottle

COSA-TETRACYDIN*

glucosamine potentiated tetracycline-analgesic-antihistamine compound

For relief of symptoms and malaise of the common cold and prevention of secondary complications

CAPSULES (black and orange) Ea. capsule contains: Cosa-Tetracyn 125 mg. • phenacetin 120 mg. • caffeine 30 mg. • salicylamide 150 mg. • buclizine HCl 15 mg.

REFERENCES: 1. Carlozzi, M.: Ant. Med. & Clin. Therapy 5:146 (Feb.) 1958. 2. Welch, H.; Wright, W. W., and Staffa, A. W.: Ant. Med. & Clin. Therapy 5:52 (Jan.) 1958. 3. Marlow, A. A., and Bartlett, G. R.: Glucosamine and Leukemia. Proc. Soc. Exp. Biol. & Med. 84:41, 1953. 4. Shalowitz, M.: Clin. Rev. 1:25 (April) 1958. 5. Nathan, L. A.: Arch. Pediat. 75:251 (June) 1958. 6. Cornbleet, T.; Chesrow, E., and Barsky, S.: Ant. Med. & Clin. Therapy 5:328 (May) 1958. 7. Stone, M. L.; Sedlis, A., Bamford, J., and Bradley, W.: Ant. Med. & Clin. Therapy 5:322 (May) 1958. 8. Harris, H.: Clin. Rev. 1:15 (July) 1958.

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Proven in research

1. Highest tetracycline serum levels
2. Most consistently elevated serum levels
3. Safe, physiologic potentiation (with a natural human metabolite)

And now in practice

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X-RAYS SHOW HOW ONE PYRIBENZAMINE® LONTAB®

relieves allergy all day or all night

The unretouched X-ray films show how Lontabs release medication in the digestive tract. So that the prolonged erosion of the Lontab core could be visualized by X-ray, subject was given 10 Lontabs, each containing 100 mg. of a radiopaque substance in place of Pyribenzamine.

With its unique formulation, the Pyribenzamine Lontab not only relieves allergy symptoms promptly, but sustains relief as long as 12 hours.

Special outer shell releases 33 mg. Pyribenzamine hydrochloride within 10 minutes.

Unique core releases approximately 18 mg. Pyribenzamine hydrochloride the 1st hour, approximately 50 mg. from the 2nd to the 12th hour.

SUPPLIED: Pyribenzamine *Lontabs* — full-strength — 100 mg. (light blue).

NOW AVAILABLE: Pyribenzamine *Lontabs* — half-strength — 50 mg. (light green) — for children over 5 and for adults who require less antiallergic medication.

PYRIBENZAMINE® hydrochloride (tripelennamine hydrochloride CIBA)
LONTABS® (long-acting tablets CIBA)

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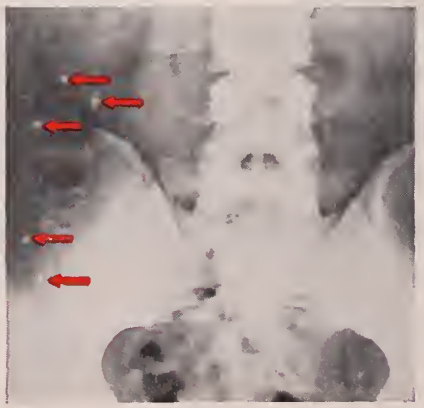
2 hours Lontabs are in the stomach and small bowel. Release of core substance is well under way.

4 hours Lontabs are in the ileum and cecum as core has steadily eroded.

8 hours Lontabs are still visible as substance of core continues to be released.



proven effective and unusually well tolerated in over 600 clinical studies

■ does not impair mental efficiency or physical performance ■ relieves both mental and muscular tension ■ does not affect autonomic function

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meprobamate (Wallace)

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9, April 1956. 179. Friedman, A. P.: The treatment of chronic headache with mepro- Use of tranquilizers in the treatment of headache. Am. Pract. & Digest Treat. 8:94, .M.A. 163:1111, March 30, 1957. 182. Friedman, H. T. and Merwelzat, W. L.: Adverse rcbamate [Miltown] - a clinical study. Am. J. Psychiat. In press, 1957. 184. Gibbs, Relaxant effects of meprobamate in disabilities resulting from muscul skeletal and 153, July 1956. 186. Gillette, H. E.: The effect of meprobamate on cerebral palsy. ers and purpura hemorrhagica (Correspondence). J.A.M.A. 161:76, May 5, 1956. 188. An evaluation of meprobamate in the treatment of alcoholism. Ann. New York Acad. Sc. "Habit-forming" individuals (Queries and Minor Notes). J.A.M.A. 163:335, Feb. 9, o. Ohio M. J. 52:1306, Dec. 1956. 192. Hollister, L. F., Elkins, N., Haler, E. C. ad. Sc. 67:709, May 9, 1957. 193. Hollister, L. F., Hammond, A. N. and Drake, C. F.: 194. Holosbek, J. E., Thomas, O. G. and St[illegible], J.: Toxic reaction to 2-methyl- 95. Karli[illegible] Conad. robamate (M[illegible]) & Throat. tranquiliz[illegible], meprobamate -- Its use for pain associated with cancer, preliminary rbamate (Correspondence). J.A.M.A. 161:644, June 16, 1956. 1[illegible]. Kugelmass, I. N.: . P. Clinic[illegible] Correspond- obamate in [illegible] May 9, 1957. J. Chronic [illegible] drugs. North-). J.A.M.A. 160:1431, April 21, 1956. 205. Lemere, F.: Habit-forming properties of 56. 206. Lemere, F.: Phenothiazine (Sparine) in the treatment of psychiatric disorders. A. Arch. D[illegible] C. F.: Un- LeVan, P. [illegible] -- A Clinical evaluation of meprobamate in disturbed and prepsychotic children. Ann. New .: Ineffectiveness of Diamox in the treatment of childhood epilepsy. Pediatrics 17: in treatment. Southwestern Med. 37:428, July 1956. 213. McG[illegible], R. R.: Drug reaction town in the treatment of chronically ill psy[illegible] Pennsylvania M. J. ychiatric [illegible] 198[illegible] M. G., Boyd, blication, [illegible] 17. O[illegible] Treatment [illegible] meprobamate Osinski, W. [illegible] of anxiety states with meprobamate. [illegible] York Acad. spondence). J.A.M.A. 163:480, Feb. 9, 1957. 220. Pelner, L.: Meprobamate (Correspond- of six ataraxics in neuropsychiatric patients. Read at the American Psychosomatic robamate, tranquilizing drug [illegible] cases, in 1957, pp. 125-131. [illegible] M. [illegible] of six ataraxics in cn, V. M.: A two-year comparative study of ataraxics in neuropsychiatric patients. J. n (meprobamate) with psychotic patients. Am. J. Psychiat. 114:257, Sept. 1957. 226. 7. 227. Perrington, V. M.: Addition to meprobamate mentioned (Correspondence). North- in convulsive and related disorders. J.A.M.A. [illegible] Pevey, J. with phen[illegible] Pharmacol. & iltown) for the treatment of emotional [illegible] Pract. & Digest Treat. 7:1573, tion. [illegible] in anx- 956. 233. [illegible] pre-anes- S. B.: The effects of ward t[illegible] on the quantity and quality of tranquilizer uti- The valu[illegible] of muscle relaxants in disorders of muscle tone. Ann. New York Acad. Sc. Hypotensive [illegible] with meprobamate (Correspondence). [illegible] 2: g drug: use [illegible] J.A.M.A. new tranquil[illegible] J. Ill[illegible] 239. S[illegible] ode Island M[illegible] Three cases O.: 'Mood' [illegible] M. Tiron P.: Meprobamate (Miltown) in rheumatic diseases. J.A.M.A. [illegible] 16, 1957. spasm due [illegible] 1957. 244. eriatrics Soc. 5:152, Feb. 1957. 245. Smith, R. T.: The newer drugs in the treat- adelphia, March, 1957, pp. 353-358. 246. Sokoloff, O. J.: Meprobamate (Miltown) as , Oct. 1956. 247. Steffen, C. G., Chervin, N. and Van Vranken, B.: Reaction follow- Stewart, R. H.: The use of tranquilizing drugs in gynecology. West. J. Surg. 64: land J. Med. 256:354, Feb. 21, 1957. 250. Thal, N.: Premedication for electroshock 7:52, Feb. 1956. 251. Thimann, J.: Newer drugs in the treatment of acute alcoholism ng, Atlanta, Georgia, Dec. 28, 1955. 252. Thimann, J. and Gauthier, J. W.: Miltown 17:19, March 1956. 253. Tucker, W. I.: The place of Miltown in general practice. l evaluation of meprobamate therapy in a chronic schizophrenic population. Am. J. . Surg., Gynec. & Obst. 104:233, Feb. 1957. 256. Turvey, S. E. C.: Meprobamate for 63, June 1956. 257. van de Erve, J. and Childs, D. R.: Meprobamate reactions. J. cas (The new ataractic drugs). Prensa méd. argent. 43:2667, Aug. 31, 1956. 259. Wein-

"ankle-itis"
there's pain and
inflammation here...
it could be mild
or severe, acute or
chronic, primary or
secondary fibrositis — or even
early rheumatoid arthritis

more potent and comprehensive treatment than salicylate alone

. assured anti-inflammatory effect of low-dosage corticosteroid[1] . . . additive antirheumatic action of corticosteroid plus salicylate[2-5] brings rapid pain relief; aids restoration of function . . . wide range of application including the entire fibrositis syndrome as well as early or mild rheumatoid arthritis

more conservative and manageable than full-dosage corticosteroid therapy—

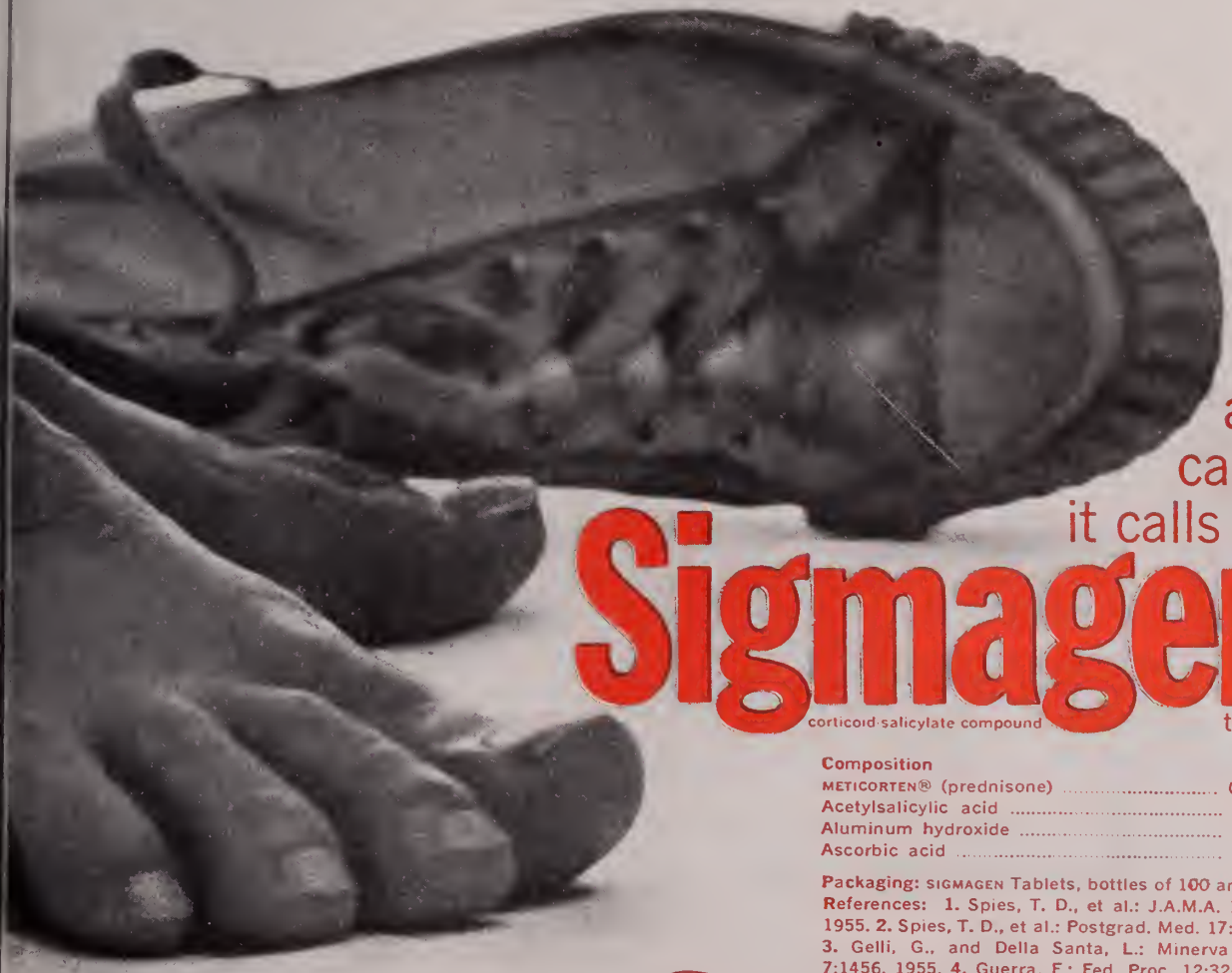
. much less likelihood of treatment-interrupting side effects[1-6] . . . reduces possibility of residual injury . . . simple, flexible dosage schedule

THERAPY SHOULD BE INDIVIDUALIZED

acute conditions: Two or three tablets four times daily. After desired response is obtained, gradually reduce daily dosage and then discontinue.

subacute or chronic conditions: Initially as above. When satisfactory control is obtained, gradually reduce the daily dosage to minimum effective maintenance level. For best results administer after meals and at bedtime.

precautions: Because SIGMAGEN contains prednisone, the same precautions and contraindications observed with this steroid apply also to the use of SIGMAGEN.



in any case it calls for

Sigmagen®

corticoid-salicylate compound tablets

Composition

METICORTEN® (prednisone)	0.75 mg.
Acetylsalicylic acid	325 mg.
Aluminum hydroxide	75 mg.
Ascorbic acid	20 mg.

Packaging: SIGMAGEN Tablets, bottles of 100 and 1000.

References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

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THIRD AND TWELFTH DISTRICTS NEWS

Doctor Welke Retires After 39 Years

Dr. E. G. Welke of Madison has retired after 39 years of medical practice. He was associated with the late Dr. W. J. Ganser in the same office suite since 1922. Doctor Welke was graduated from Marquette University School of Medicine in 1919 and practiced medicine for the first three years at Lime Ridge, Wisconsin. He served in the Army during World War I.

Doctor Turgeson Opens Madison Practice

Dr. John H. Turgeson recently joined *Dr. John P. Malec* and the Associated Physicians in Madison in the practice of general and thoracic surgery. He was graduated from the University of Wisconsin Medical School and took a surgical residency at Madison General Hospital. For the past year he has been associated with hospitals in California.

Doctor Rahm Joins Monona Grove Clinic

Dr. John P. Rahm, a native of Michigan, has become affiliated with the Monona Grove Clinic in Madison in the practice of surgery. Following his graduation from the University of Michigan, he both interned and took a residency in surgery at Hurley General Hospital in Flint, Michigan.

Attends Hypnosis Meeting

Dr. Emil Franklin of Milwaukee attended the annual meeting of the American Society of Clinical Hypnosis which was held October 3 and 4 at the Conrad Hilton Hotel in Chicago.

Doctor Franklin will participate in the scientific program of the Society for Clinical and Experimental Hypnosis at its annual meeting to be held October 29 to 31 at the Morrison Hotel in Chicago. He will conduct a luncheon round-table on "Hypnosis in General Practice." Doctor Franklin's paper will be published in a winter issue of the British Journal of Medical Hypnotism, according to its editor, Dr. S. J. Van Pelt.

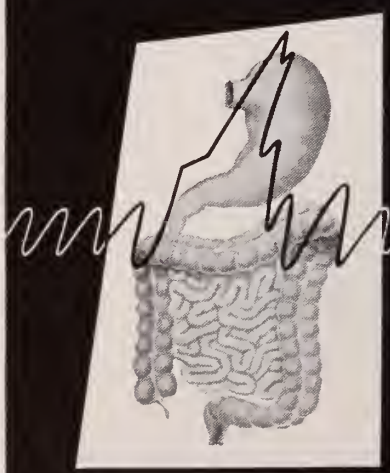
Doctor Rock Joins East Madison Clinic

The East Madison Clinic recently announced the addition of *Dr. William Rock* to its staff. Doctor Rock specializes in internal medicine.

Last year Doctor Rock was on the staff of the Veterans Hospital in Madison, serving a fellowship in chest diseases. He has also been a clinical instructor at the University of Wisconsin Medical School.

Doctor Rock received his medical degree from Loyola University, Chicago, and was in residency for three years at Mercy Hospital and Westside Veterans Hospital in Chicago.

in spasticity of the GI tract



Pavatrine®
125 mg.
with Phenobarbital
15 mg.

- *is an effective dual antispasmodic*
- *combining musculotropic and neurotropic action plus mild central nervous system sedation for "the butterfly stomach."*

dosage: one tablet before each meal and at bedtime.

SEARLE

To Speak in New York City

Dr. Edgar S. Gordon, Professor of Medicine, and *Dr. Milton H. Miller*, Assistant Professor of Psychiatry, of the University of Wisconsin Medical School participated in the program of the Fifth Annual Meeting of the Academy of Psychosomatic Medicine held October 9–11 at the Park Sheraton Hotel in New York City.

Doctor Gordon was a panelist on the subject, "Cholesterol Metabolism, Coronary Disease and Stress." Doctor Miller was a panelist on the subject, "Recognition and Management of the Borderline Psychotic." He also led a discussion on "The Psychic Actions of the Newer Drugs."

Speaks in London

The dean of the University of Wisconsin Medical School, *Dr. John Z. Bowers*, spoke in London before the British Association for the Study of Medical Education. Doctor Bowers left September 15 for the September 25–26 first meeting of the new organization. His talk was on "The Study of Medical Education in the U.S." The trip to speak before and consult with British medical educators was sponsored by the Rockefeller Foundation and included conferences at the Universities of Oxford, Cambridge, Edinburgh, and London.

Doctor Thornton Is Delegate at International Meet

Dr. Madeline Thornton was present for the meetings of the International Federation of Gynecology and Obstetrics in Montreal, Canada, June 22–28. Doctor Thornton, who is on the staff of the University of Wisconsin Medical School, attended as one of four delegates appointed by the American College of Obstetricians and Gynecologists as representative of the General Assembly.

Dr. M. D. Davis Attends Eastern Conference

An invitational conference conducted by a group of American and European leaders in the field of retinal detachment was attended by *Dr. Matthew D. Davis*, of Madison. The meeting, held at Castle Hill, Ipswich, Massachusetts, featured talks on special problems in complicated retinal detachments.

Doctor Smith Begins Practice in Janesville

Dr. David A. Smith, who has completed his residency at Milwaukee Hospital, recently joined *Dr. Marshall F. Purdy* of Janesville in the practice of internal medicine. Doctor Smith was graduated from the University of Wisconsin Medical School and is a veteran of World War II.

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A 65-bed institution for the treatment of nervous and mental illnesses.

Illustrated booklets sent on request.

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Tao*

PRONOUNCED TAY-O

(brand of triacetyloleandomycin with gluCOSAmine)

Capsules / Oral Suspension

designed for effective control of common gram-positive infections

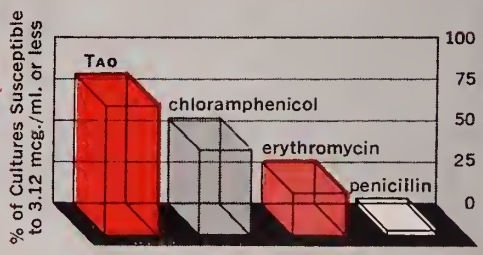
effective . . .

CLINICAL RESULTS	adults	children	all Staph infections
Cured	172 (80%)	148 (89%)	71 (88%)
Improved	28 (13%)	8 (5%)	7 (9%)
Failure	17 (7%)	11 (6%)	3 (3%)

Types of infecting organisms: The majority of identified etiologic microorganisms were Staph. aureus and Staph. albus. Tao has its greatest usefulness against organisms such as: staphylococci (including strains resistant to other antibiotics), streptococci (beta-hemolytic strains, alpha-hemolytic strains and enterococci), pneumococci, gonococci, Hemophilus influenzae.

even against resistant staph[1,2] . . .

Per cent of "antibiotic-resistant" epidemic staphylococci cultures susceptible to Tao, erythromycin, penicillin and chloramphenicol.[1]



well tolerated . . .

REACTIONS:

(a) adults
Total—9.2%
(20 out of 217)
Skin rash—1.4%
(3 out of 217)
Gastrointestinal—
7.8% (17 out of 217)

(b) children
Total—0.6%
(1 out of 167)
Skin rash—none
Gastrointestinal—
0.6% (1 out of 167)

There was complete freedom from adverse reactions in 94.5% of all patients. Side effects in the other 5.5% were usually mild and seldom required discontinuance of therapy.

plus . . . stability in gastric acid • rapid, high and sustained blood levels • high urinary concentrations • outstanding palatability in a liquid preparation

Dosage and Administration: Dosage varies according to the severity of the infection. For adults, the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. For children 8 months to 8 years of age, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective. Since Tao is therapeutically stable in gastric acid, it may be administered at any time, without regard to meals.

Supplied: Tao Capsules—250 mg. and 125 mg.; bottles of 60. Tao for Oral Suspension—1.5 Gm.; 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

References: 1. English, A. R., and Fink, F. C.: Antibiotics & Chemother. (Aug.) 1958. 2. English, A. R., and McBride, T. J.: Antibiotics & Chemother. (Aug.) 1958. 3. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy (Aug.) 1958. 4. Celmer, W. D., et al.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 476.

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Division, Chas. Pfizer & Co., Inc. SCIENCE FOR THE WORLD'S WELL-BEING

*TRADEMARK

College of Physicians Met

Members of the American College of Physicians from Illinois, Indiana, Iowa, Minnesota and Wisconsin met Sept. 27 at Milwaukee County Hospital for the Midwest Regional meeting. A scientific program of 22 papers was presented. A noon luncheon, banquet and entertainment comprised the day's activities in addition to the program.

Dr. Frederick W. Madison is governor for Wisconsin; *Dr. Joseph W. Rastetter*, general chairman; Dr. Mark W. Garry, treasurer; *Dr. M. C. F. Lindert*, chairman, Committee on Scientific Program; *Dr. Daniel G. Santer*, chairman, Committee on Convention Hall and Projection Apparatus; *Dr. Paul G. LaBissoniere*, chairman, Committee on Publicity; *Dr. Harold M. Coon*, chairman, Committee on Luncheon; and *Dr. Timothy R. Murphy*, chairman, Committee on Banquet and Entertainment. All are fellows of the academy. Mrs. Joseph W. Rastetter was chairman of the Committee on Ladies' Entertainment. About 1,000 members attended.

To Expand and Remodel

An extensive program of expansion and remodeling has been started at the Wisconsin Neurological Foundation, 1954 East Washington Avenue, Madison. The project will provide for increased neurological facilities, all phases of rehabilitation, and additional patient bed space.

The cost of the total project will be $533,000. A rehabilitation facilities' grant from the Wisconsin State Board of Vocational and Adult Education, Rehabilitation Division, will aid in this construction. The Foundation was established in 1950.

"Grand Rounds" Films at Lancaster Memorial Hospital

Starting September 23, *Dr. Robert D. Jackson* begun showing all the "Grand Rounds" films. The showings will continue each Tuesday through October at the Lancaster Memorial Hospital, Lancaster, Wis. An informal discussion period is held after each showing. Any physician is welcome to attend any or all showings.

General Practice Program at University of Wisconsin

November 6, 7 and 8 are the dates for the postgraduate course in general practice to be held at the University of Wisconsin. Departments of Medicine, Pediatrics, Surgery, Psychiatry and Obstetrics and Gynecology will participate.

Of special significance to the physician is the symbol

When he sees it engraved on a Tablet of Quinidine Sulfate he has the assurance that the Quinidine Sulfate is produced from Cinchona Bark, is alkaloidally standardized, and therefore of unvarying activity and quality.

When the physician writes "DR" (Davies, Rose) on his prescriptions for Tablets Quinidine Sulfate, he is assured that this "quality" tablet is dispensed to his patient.

Rx Tablets Quinidine Sulfate Natural
0.2 Gram (or 3 grains)
Davies, Rose

Clinical samples sent to physicians on request

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premenstrual

'DIURIL'

(CHLOROTHIAZIDE)

FORD, R. V., Rochelle, J.B.III, Handley, C. A., Moyer, J. H. and Spurr, C. L.: J.A.M.A. **166**:129, Jan. 11, 1958.

". . . in premenstrual edema, convenience of therapy points to the selection of chlorothiazide, since it is both potent and free from adverse electrolyte actions." In the vast majority of patients, 'DIURIL' relieves or prevents the fluid "build-up" of the premenstrual syndrome. The onset of relief often occurs within two hours following convenient, oral, once-a-day dosage. 'DIURIL' is well tolerated, does not interfere with hormonal balance and is continuously effective—even on continued daily administration.

DOSAGE: one 500 mg. tablet 'DIURIL' daily—beginning the first morning of symptoms and continuing until after onset of menses. For optimal therapy, dosage schedule should be adjusted to meet the needs of the individual patient.

SUPPLIED: 250 mg. and 500 mg. scored tablets 'DIURIL' (chlorothiazide); bottles of 100 and 1,000.

DIURIL is a trade-mark of Merck & Co., Inc.

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(EDEMA)

quickly relieves
Distress
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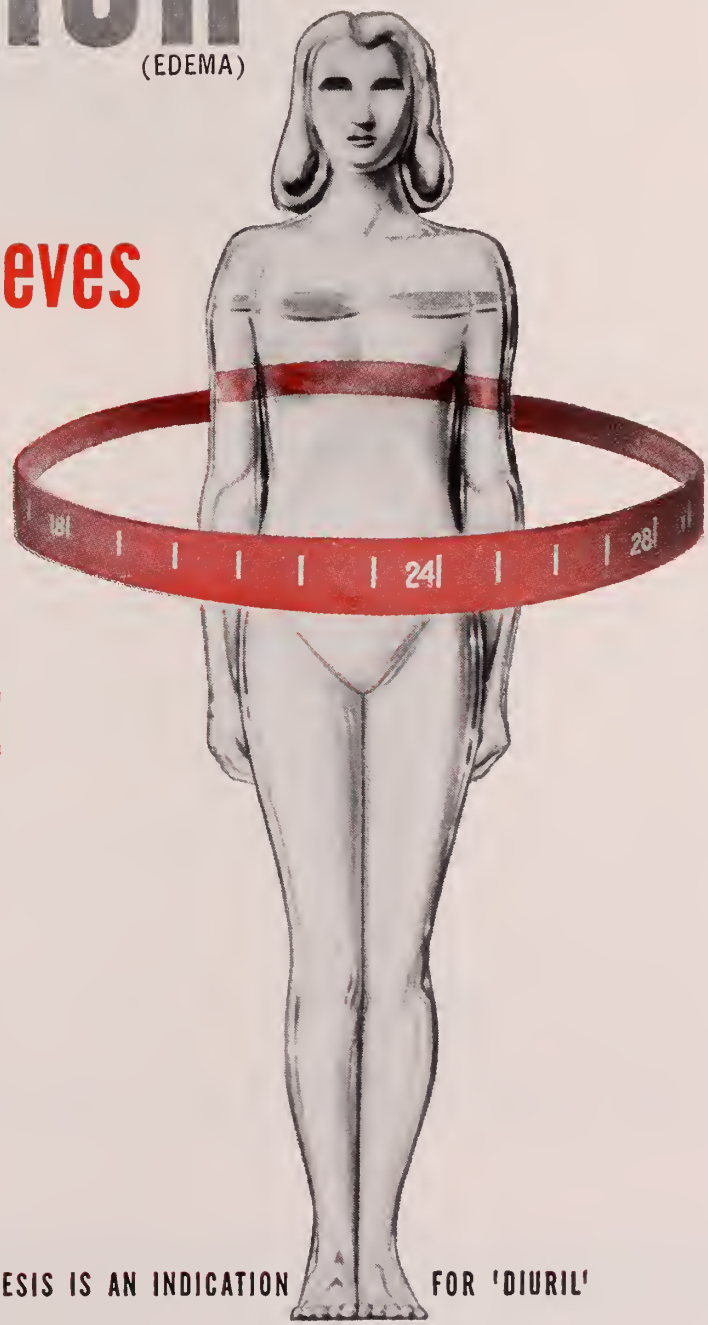
Discomfort



ANY INDICATION FOR DIURESIS IS AN INDICATION FOR 'DIURIL'

Don't forget, Doctor—
"to take some of your own medicine!"

On vacation — at the beach — on the golf course — or gardening in your own back yard, sunburn, insect bites, cuts and abrasions are all part of the summer picture.

A handy tube of Xylocaine Ointment means prompt relief of pain, itching and burning for your patients. After you've seen to your patients' comfort, remember that tube of Xylocaine Ointment for yourself.

Just write "Xylocaine Ointment" on your Rx blank or letterhead, and we will send a supply for you and your family.

Astra Pharmaceutical Products, Inc., Worcester 6, Mass., U.S.A.

XYLOCAINE® OINTMENT
(brand of lidocaine*)

2.5% & 5%

SURFACE ANESTHETIC

SEE PDR

*U. S. Pat. No. 2,441,498 Made in U. S. A.

"THE DOCTORS' PLAN"

THE BLUE SHIELD PLAN
OF THE
STATE MEDICAL SOCIETY OF WISCONSIN

Facts about WISCONSIN PHYSICIANS SERVICE

PREPARED BY THE COMMISSION ON MEDICAL CARE PLANS

WPS HOSPITAL BENEFITS FOR MATERNITY CARE

The new WPS hospital plan provides the purchaser with three options in choosing benefits for maternity care.

OPTION A—The Ten Times Benefit:

Under this option hospital charges for both mother and child in connection with pregnancy or child birth will be paid up to an amount equal to ten (10) times the selected room benefit. For example, if the patient selects the $12.00 per day room and board benefit a total of $120.00 would be available for room and board and miscellaneous services in connection with the hospitalization for child birth.

The benefits available under this option apply to cases involving termination of pregnancy. Complications occurring before or after delivery are paid as regular benefits. Regular benefits call for payment of room and board up to the maximum of the selected room rate for a maximum of 120 days, and full payment of all regular hospital charges for miscellaneous expenses.

OPTION B—The Ten Day Benefit:

Under this option benefits for room and board and miscellaneous services will be paid for mother and child for ten days in connection with any one pregnancy or child birth. As in option A, this benefit applies to cases involving termination of pregnancy. Complications occurring before or after delivery are paid as regular benefits.

OPTION C—The 120 Day Benefit:

Under this option benefits for room and board and miscellaneous expenses will be paid for mother and child for 120 days in connection with pregnancy or child birth including complications occurring before or after delivery.

No matter which option is taken, a family contract must have been in effect for nine consecutive months, or waiting periods must have been waived by WPS.

Option A is the least expensive. Options B and C are correspondingly increased in cost as the benefit increases.

Maternity benefit payments are available in all instances in which pregnancy had its inception while the participant was insured under the WPS contract.

For Information or Advice

Write: P. O. Box 1109, MADISON, WIS. **Phone:** ALpine 6–3101, MADISON, WIS.

Low Dosage KYNEX* for G.U. Infections

Sulfamethoxypyridazine Lederle

Unusual Antibacterial and Anti-infective Properties—More soluble in acid urine[1] . . . higher and better sustained plasma levels than any other known and useful antibacterial sulfonamide.[2]

Unprecedented Low Dosage—Less sulfa for the kidney to cope with . . . yet fully effective. A single daily dose of 0.5 to 1.0 Gm. maintains higher plasma levels than 4 to 6 Gm. daily of other sulfonamides—a notable asset in prolonged therapy.[2]

Dosage: The recommended adult dose is 1 Gm. (2 tablets) the first day, followed by 0.5 Gm. (1 tablet) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours.

KYNEX—WHEREVER SULFA THERAPY IS INDICATED

Tablets: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

Syrup: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

references:

1 Grieble, H.G., and Jackson, G.G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958

2. Editorial: *New England J. Med.* 258:48-49, 1958.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

*Reg. U.S. Pat. Off.

ARTHRITIS... OR GOUT?

GOUT—THE DIAGNOSTIC PROBLEM

Clinical "curiosity" rather than clinical "instinct" is the key to accurate diagnosis of gout. Visible manifestations may not appear until late in the course of the disease. Moreover, the patient's description of the pain and the site of the pain may not differ markedly from other articular disorders.

THE FOLLOWING FINDINGS ARE HIGHLY INDICATIVE OF GOUT: (1) *Tophaceous deposits* resulting in irregular, asymmetrical deformity of joints; (2) *Elevated serum uric acid levels* (above 6 mg.%); (3) *Pain relief with colchicine.* When findings suggest gout, therapy with 'Benemid' should be started immediately.

BENEMID®—AN EFFECTIVE URICOSURIC AGENT

'Benemid' is firmly established as an *effective* and exceptionally *safe* uricosuric agent. 'Benemid' approximately doubles the excretion of uric acid; reduces serum uric acid levels toward normal; often prevents formation of new tophi, and gradually mobilizes existing uric acid deposits; minimizes incidence and severity of future attacks.

'Benemid' is of remarkably low toxicity—usually so low as to be clinically insignificant—even in patients who have been on uninterrupted therapy for almost a decade. The uricosuric effects of salicylates and 'Benemid' are mutually antagonistic and these compounds should not be used together.

RECOMMENDED DOSAGE: 0.25 Gm. (½ tablet) twice daily for one week followed by 1 Gm. (2 tablets) daily in divided doses.

BENEMID®

PROBENECID

A SPECIFIC FOR GOUT

MSD MERCK SHARP & DOHME

DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA

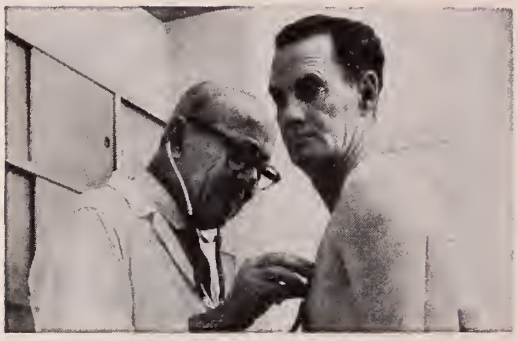
BENEMID is a trade-mark of Merck & Co., Inc

Pyribenzamine® EXPECTORANT breaks up cough

even persistent cough

Patient, factory worker, age 43, had suffered for months with persistent, dry cough, which he termed "smoker's hack."

Cough frequently interrupted his sleep, causing him to be nervous, irritable; his job efficiency was impaired.



Chest X-ray was negative and the plant physician prescribed PYRIBENZAMINE EXPECTORANT with Ephedrine. Patient noticed almost immediate relief—a week later felt "considerably better."

Pyribenzamine Expectorant with Ephedrine provides a unique combination of antitussive agents, which work three ways at once to break up the persistent cough: *Pyribenzamine* relieves histamine-induced congestion throughout the respiratory tract; *ephedrine* relaxes the bronchioles and makes breathing easier; *ammonium chloride* liquefies mucus, relieving dry cough and promoting productive expectoration.

Supplied: Pyribenzamine *Expectorant with Ephedrine*, containing 30 mg. Pyribenzamine citrate (equivalent to 20 mg. Pyribenzamine hydrochloride), 10 mg. ephedrine sulfate and 80 mg. ammonium chloride per 4-ml. teaspoon.

Also available: Pyribenzamine *Expectorant with Codeine and Ephedrine*, same formula as above with the addition of 8 mg. codeine phosphate per 4-ml. teaspoon (exempt narcotic).

Pyribenzamine® citrate (tripelennamine citrate CIBA) 2/2559MK

CIBA SUMMIT, N. J.

Achromycin V*

TETRACYCLINE WITH CITRIC ACID LEDERLE

ASSURES EVERY PATIENT PRECISE

ANTIBIOTIC ACTION UNDER THE VARIED

CONDITIONS OF REALISTIC CLINICAL PRACTICE

produces optimal gastric conditions

Ideally, most antibiotics are given on an empty stomach. Since citric acid helps control unfavorable variances in gastric content, conditions in the stomach are optimal with ACHROMYCIN V tetracycline with citric acid.

prevents interference with absorption

Sequestering of antibiotic molecules by free metallic ions, always present in the intestinal tract, can deprive patients of a full therapeutic dose. The three active carboxyl radicals which protect the action of ACHROMYCIN V trap these free cations and allow uninhibited antibiotic absorption.

provides for peak antibiotic action

At the site of infection where, in essence, all antibiotics are proved, ACHROMYCIN V combats a wide range of pathogens under optimal tissue conditions. Citric acid, a factor of medically established value in the natural acid-base regulating mechanism of the G.I. tract, facilitates a more complete, and rapid antibiotic action.

MORE DOCTORS PRESCRIBE ACHROMYCIN V THAN ANY OTHER BROAD-SPECTRUM ANTIBIOTIC

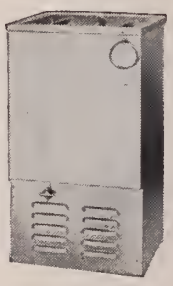
Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y.

Make sparkling radiographs...

order fresh SUPERMIX® TODAY

SUPERMIX LIQUIDS	DEVELOPER	REFRESHER	STAIN-LESS FIXER*	SPEED FIXER
26 oz. makes 1 gal.	$1.42	$1.42	$1.22	$1.27
12 or more, each	1.28	1.28	1.10	1.14
80 oz. makes 3 gal.	3.84			3.52
4 or more, each	3.46			3.17
1 gal. makes 5 gal.	5.07	5.07	4.25	4.61
4 or more, each	4.56	4.56	3.83	4.15

*Comes in 1 and 5 qt. only, to make 1 and 5 gal. of solution.



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The purity, the wholesomeness, the quality of Coca-Cola as refreshment has helped make Coke the best-loved sparkling drink in all the world.

DRINK Coca-Cola REG. U.S. PAT. OFF.

SIGN OF GOOD TASTE

AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS

Plans have been made for the Second Annual Convention of the American Association of Medical Assistants to be held at the Palmer House, Chicago, Illinois on October 31, November 1, and 2, 1958.

The American Association of Medical Assistants is made up of men and women employed as assistants in the offices of Doctors of Medicine. The Association was conceived in Kansas City, Kansas during the fall of 1955 when interested persons from fifteen states met to make plans for a formal organization. The second meeting was held the following year in Milwaukee, Wisconsin at which time a Constitution and By-laws were adopted and the Association formally set up. During this first official year, a great deal of work was done and the First Annual Convention was held in San Francisco, California in October, 1957. Now, with a membership of nearly 6,000 representing seventeen states, and with the approval of State Medical Societies and the American Medical Association, this Association is well under way.

The purposes of the Association are stated as follows: To inspire its members to render honest, loyal and more efficient service to the profession and to the public which they serve. To strive at all times to cooperate with the medical profession in improving public relations. To render educational services for the self-improvement of its members and to stimulate a feeling of fellowship and cooperation among the Societies. To encourage and assist all unorganized medical assistants in forming local and State societies. This Association is declared to be non-profit. It is not nor shall it ever become a trade union or collective bargaining agency.

(Continued on page 75)

Malpractice Prophylaxis

Maintaining
Unimpeachable
Records

Specialized Service makes our doctor safer

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FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

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The Beautiful EMPIRE Dining Room
Music and Dancing—At Lunch, Dinner, After Theatre
Music By America's Leading Bands
Air Conditioned

HOTEL SCHROEDER
MILWAUKEE
WALTER SCHROEDER, President

the chill

the cough

the aching muscles

the fever

Viral upper respiratory infection. . . . For this patient, your management will be twofold—prompt symptomatic relief plus the prevention and treatment of bacterial complications. PEN·VEE·*Cidin* backs your attack by broad, multiple action. It relieves aches and pains, and reduces fever. It counters depression and fatigue. It alleviates cough. It calms the emotional unrest. And it dependably combats bacterial invasion because it is the only preparation of its kind to contain penicillin V.

SUPPLIED: Capsules, bottles of 36. Each capsule contains 62.5 mg. (100,000 units) of penicillin V, 194 mg. of salicylamide, 6.25 mg. of promethazine hydrochloride, 130 mg. of phenacetin, and 3 mg. of mephentermine sulfate.

PHYSICIANS' COUNCIL · INFORMATION ON CHILD HEALTH

This advertisement conforms to the Code for Advertising of the Physicians' Council for Information on Child Health.

PEN·VEE·*Cidin*®

Wyeth®

Penicillin V with Salicylamide, Promethazine Hydrochloride, Phenacetin, and Mephentermine Sulfate, Wyeth

Philadelphia 1, Pa.

(Continued from page 73)

Several states now offer fine educational courses with the cooperation of their colleges and universities which will help the assistant to become more valuable in the doctor's office. Physicians realize that the well-trained assistant is an asset to their profession and that these courses will relieve them of much of the time-consuming work of on-the-job training. The American Association plans to offer courses on a national level as soon as a suitable curriculum has been set up.

Membership in medical assistants societies throughout the country has provided an opportunity for the assistant to benefit from the many fine lectures, workshops and seminars as a part of regular programs.

The American Association of Medical Assistants is now offering its members a comprehensive insurance program. This is a salary replacement (sickness and accident) plan with optional major hospital, nurse expense and surgical benefits.

It is to the advantage of the medical profession to have their medical assistants affiliated with this organization.

The American Association of Medical Assistants would welcome the opportunity to give information concerning the organization and to assist with the formation of County and State Societies. Inquiries may be addressed to Miss Hallie Cummins, R.R.L., Chairman of the Public Relations Committee, Medical Record Library Caro State Hospital for Epileptics, Caro, Michigan.

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Treating alcoholism and other problems of addiction.
REGISTERED BY THE AMERICAN MEDICAL ASSOCIATION—
MEMBER AMERICAN HOSPITAL ASSOCIATION.

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MEDICAL-DENTAL-HOSPITAL BUREAUS OF AMERICA

IS SYMBOL OF ASSURANCE OF ETHICAL public relations minded handling of your accounts receivable and collection problems.

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Here Are the BUREAUS in Your Area Capable and Ready to Serve You

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why all the fuss over potassium?

Many physicians will recall when safe but potent organomercurials were first introduced. At the time there was considerable worry about possible potassium loss. Patients were instructed to take foods rich in this mineral, and not infrequently potassium supplements also were advised. After enough experience was gained, it became evident that only the exceptional case could lose enough potassium to be concerned about. And with oral organomercurial diuretics this was practically never a problem.

Why revive the subject now? Because clinical experience with nonmercurial diuretics indicates most of them have such a specific effect on potassium that with their use very real problems must be faced. Enough potassium loss can lead to digitalis toxicity or to a classical overt hypopotassemia. Since a fair percentage of cardiacs who receive diuretics are also digitalized, this excess potassium excretion is clinically serious. Clinical experience is still too limited with some nonmercurial diuretics to say just how often such loss will occur—but warnings already have been sounded by some clinical investigators as to the need for potassium supplementation.

Experience in many patients, for many years, demonstrates that potassium loss is never a problem when NEOHYDRIN® is the oral diuretic. And there is no refractoriness to this effective oral organomercurial.

LAKESIDE

all cold symptoms

New timed-release tablet provides:

...the superior decongestant and antihistaminic action of Triaminic

...non-narcotic cough control as effective as with codeine, but without codeine's drawbacks

...an expectorant to augment demulcent fluids

...the specific antipyretic and analgesic effect of well-tolerated APAP

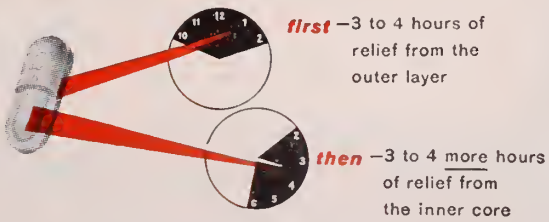
...the prompt and prolonged activity of timed-release medication

Each* Tussagesic *Tablet contains:

TRIAMINIC®	50 mg.	
(phenylpropanolamine HCl	25 mg.;	To reduce upper respiratory congestion and irritating secretions.
pheniramine maleate	12.5 mg.;	
pyrilamine maleate	12.5 mg.)	
Dormethan (brand of dextromethorphan HBr)	30 mg.	For non-narcotic control of the cough reflex.
Terpin hydrate	180 mg.	To augment demulcent respiratory secretions.
APAP (N-acetyl-para-aminophenol)	325 mg.	For specific, highly effective antipyresis and analgesia.

Tussagesic Tablets provide relief from *all* cold symptoms in minutes, lasting for hours.

Dosage: One tablet in the morning, mid-afternoon, and in the evening, if needed. The tablet should be swallowed whole to preserve the timed-release action.



Also available—for those who prefer palatable liquid medication—

Tussagesic suspension

NEW

Tussagesic

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in very special cases
a very superior brandy...
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STARTING DATES—FALL, 1958

SURGERY—Surgical Technic, Two Weeks, September 29, October 27
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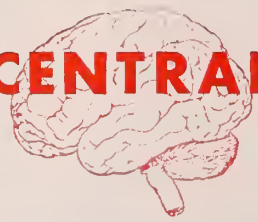
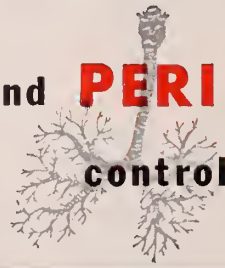
Basic Principles in General Surgery, Two Weeks, October 13
Gallbladder Surgery, Three Days, November 3
Surgery of Hernia, Three Days, November 6
General Surgery, Two Weeks, November 10; One Week, October 27
Fractures & Traumatic Surgery, Two Weeks, December 1
American Board Review Course, Two Weeks, November 10
Blood Vessel Surgery, One Week, October 20
GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, Two Weeks, October 13
Vaginal Approach to Pelvic Surgery, One Week, October 6
General & Surgical Obstetrics, Two Weeks, October 27
MEDICINE—General Review Course, Two Weeks, October 20
Electrocardiography, Two-Week Basic Course, October 6
Gastroscopy & Gastroenterology, Two Weeks, November 3
American Board Review Course, One Week, September 29
(Oversubscribed—Available again in Spring, 1959)
DERMATOLOGY—Clinical & Didactic Course, Two Weeks, November 3
UROLOGY—Two-Week Intensive Course, October 13
Ten-Day Practical Course in Cystoscopy by appointment
RADIOLOGY—Diagnostic X-Ray, Two Weeks, December 1
Clinical Uses of Radioisotopes, Two Weeks, September 29

Teaching Faculty—Attending Staff of Cook County Hospital

ADDRESS: REGISTRAR, 707 South Wood Street, Chicago 12, Illinois

Both CENTRAL and PERIPHERAL control of cough





SYNEPHRICOL® cough syrup

ANTITUSSIVE • DECONGESTANT • ANTIHISTAMINIC

Combines:
Central Antitussive Effect — mild, dependable
Topical Decongestion — prompt, prolonged
plus Antihistaminic and Expectorant Action

Winthrop LABORATORIES
NEW YORK 18, N. Y.

Each teaspoonful (4 cc.) contains:

Neo-Synephrine® hydrochloride	5.0 mg.
Thenfadil® hydrochloride	4.0 mg.
Dihydrocodeinone bitartrate	1.33 mg.
Potassium guaiacol sulfonate	70.0 mg.
Ammonium chloride	70.0 mg.
Menthol	1.0 mg.
Chloroform	0.02 cc.
Alcohol	8%

Bottles of 16 fl. oz

EXEMPT NARCOTIC

new 3-way build-up for the under par child...

Improve appetite and energy
with ample amounts of vitamins—B_1, B_6, B_{12}.

strengthen bodies with needed protein
Through the action of l-Lysine, cereal and other low-grade protein foods are up-graded to maximum growth potential.

discourage nutritional anemia
with iron in the well-tolerated form of ferric pyrophosphate...plus sorbitol for enhanced absorption of both iron and B_{12}.

new

INCREMIN* WITH IRON SYRUP

Lysine-Vitamins

delicious cherry flavor—no unpleasant aftertaste

Average dosage is 1 teaspoonful daily. Available in bottles of 4 and 16 fl. oz.

Each teaspoonful (5 cc.) contains:

l-Lysine HCl	300 mg.
Vitamin B_{12} Crystalline	25 mcgm.
Thiamine HCl (B_1)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
Sorbitol	3.5 Gm.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York Lederle

*Reg. U. S. Pat. Off.

OBITUARIES

Dr. R. B. Hoermann, a retired Milwaukee physician, passed away August 4 at his home. He was 85 years of age.

Doctor Hoermann practiced in Milwaukee for 43 years before retiring in 1953. He specialized in dermatology most of that time. A native of St. Louis, Missouri, he graduated from the University of Michigan Medical School and practiced in Watertown with his father before coming to Milwaukee.

Surviving are his widow, a brother and four sisters.

Dr. Adolph Soucek, a Madison psychiatrist, died August 30 after a brief illness. He was 51 years of age.

Doctor Soucek was born in Iowa City, Iowa, in 1907, received his medical degree from the University of Iowa in 1931 and interned at University Hospitals in Iowa City the following year. He then took postgraduate training at the New York Psychiatric Institute. Prior to coming to Madison in 1948 to assume the position of assistant superintendent of the Mendota State Hospital, Doctor Soucek practiced in three Iowa institutions, Woodward, Mount Pleasant, and Cherokee State Hospitals.

Memberships held by Doctor Soucek included those with the Dane County Medical Society, the State Medical Society of Wisconsin, the American Medical Association, and the American Psychiatric Association. He was certified by the American Board of Psychiatry in 1948.

He is survived by his widow, Mary, his parents, two brothers, and a sister.

Dr. S. W. Murphy, 79, died August 31. He had practiced in Kenosha for 37 years.

Born in Oconto in 1879, Doctor Murphy was in the teaching profession before beginning his medical studies and at one time held the position of assistant principal of the Kenosha high school. He graduated from Hahnemann Medical College and Hospital in Chicago in 1909, and returned to Kenosha immediately to set up practice.

Until his retirement in 1946, Doctor Murphy was a member of the Kenosha County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

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An institution conducted for the diagnosis and treatment of mild nervous disorders and non-infectious diseases; also for rest and recuperation under medical supervision. Equipped with every modern facility for diagnostic purposes. Scientific dietetics, physiomechanotherapy, hydrotherapy, supervised occupational and recreational activities. Literature and rates sent on request.

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CHEW

he's ready for

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New vitamin-mineral supplement in delicious chocolate-like nuggets

There's nothing easier to give or take – than Delectavites. A real treat . . . the children's favorite . . . tops with adults, too.

Each nugget contains:

Vitamin A	5,000 Units*
Vitamin D	1,000 Units*
Vitamin C	75 mg.
Vitamin E	.2 Units†
Vitamin B-1	2.5 mg.
Vitamin B-2	2.5 mg.
Vitamin B-6	1 mg.
Vitamin B-12 Activity	.3 mcg.
Panthenol	.5 mg.
Nicotinamide	20 mg.
Folic Acid	0.1 mg.
Biotin	30 mcg.
Rutin	12 mg.
Calcium Carbonate	125 mg.
Boron	0.1 mg.
Cobalt	0.1 mg.
Fluorine	0.1 mg.
Iodine	0.2 mg.
Magnesium	3.0 mg.
Manganese	1.0 mg.
Molybdenum	1.0 mg.
Potassium	2.5 mg.

*U.S.P. UNITS †INT. UNITS

Dose: One Nugget per day

Supplied: Boxes of 30—one month's supply
Boxes of 90—three months' supply or family package.

WHITE LABORATORIES, INC.,
KENILWORTH, N. J.

Society Records

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G. F. Schumacher, 3070 North 77th Street, Milwaukee.
B. J. Olsen, 3070 North 77th Street, Milwaukee.
E. J. Drvaric, 3333 South 27th Street, Milwaukee.
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Charles Benkendorf,* 1300 University Avenue, Madison.

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Provides BOTH fast and prolonged vasodilatation for practical prophylaxis in angina pectoris.
Combines TWO (Nitroglycerin and Pentaerythrital Tetranitrate) time tested coronary vasodilators in a stable and economical dosage form.
Glyceryl Trinitrate (Nitroglycerin) _1/150 gr.
Pentaerythrital Tetranitrate ____ 15 mg.
Thiamin Mononitrate _____ 5 mg.

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More than 40 registered pharmacists eager to help you.

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References: 1. Drugs of Choice 1958-1959, St. Louis, C. V. Mosby Company, 1958, p. 347.
2. Goldsmith, J. W.: Minnesota Med. *40*:99 (Feb.) 1957.

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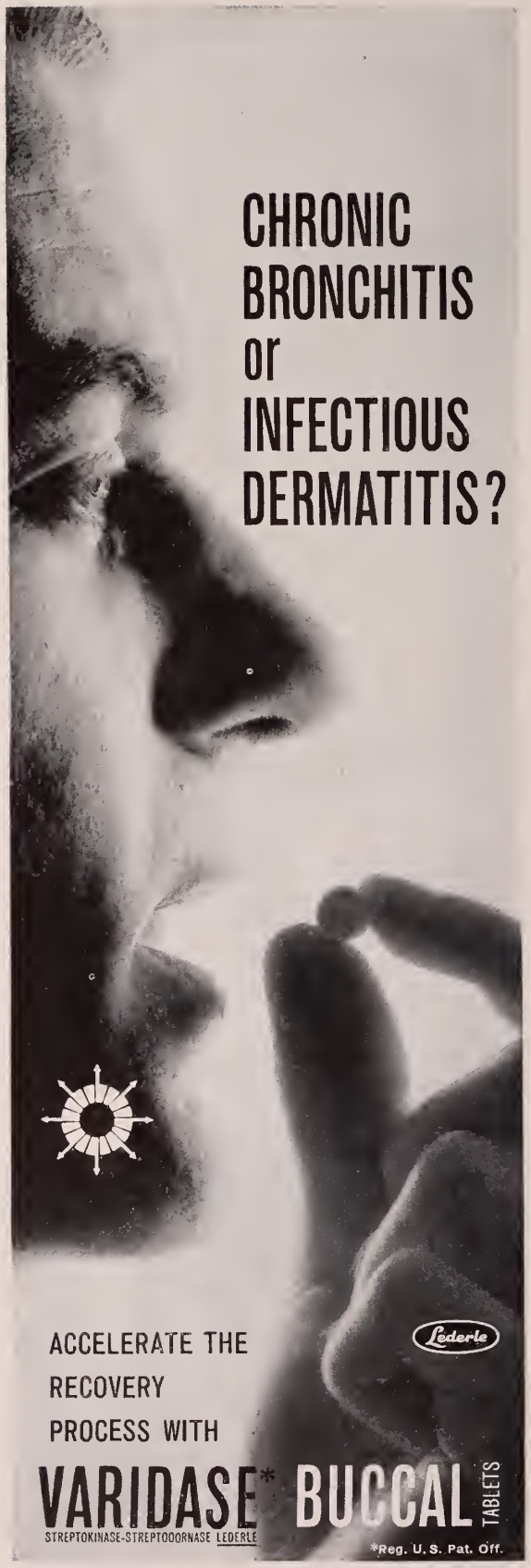

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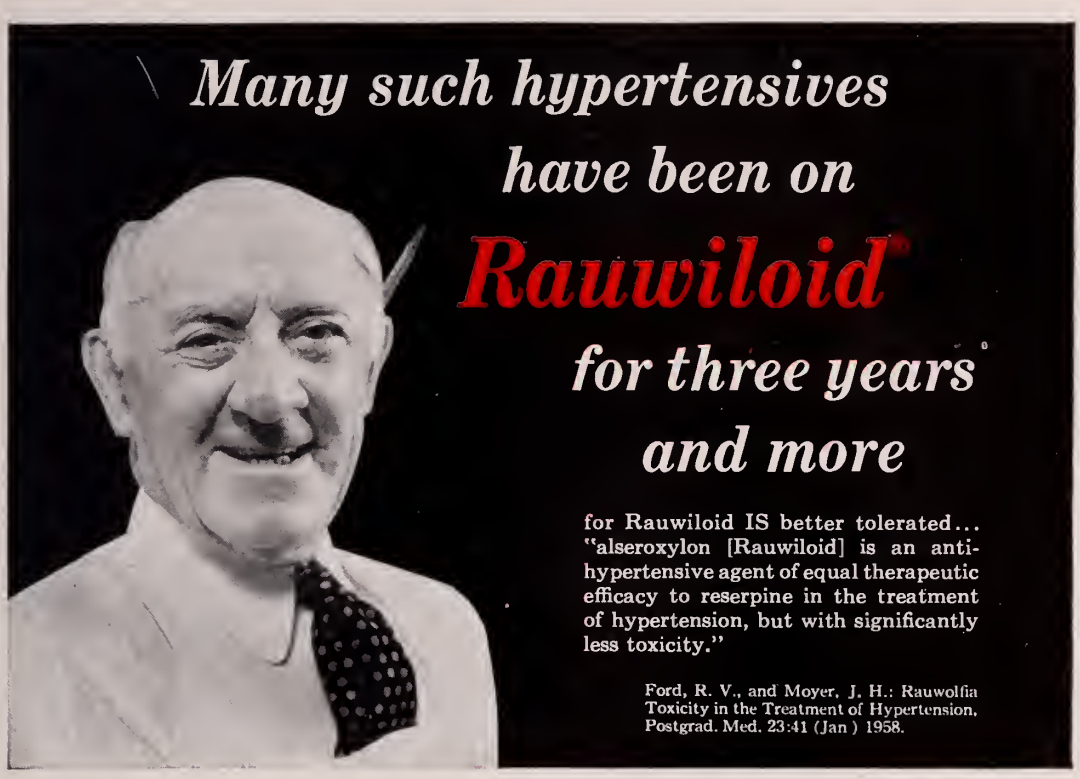

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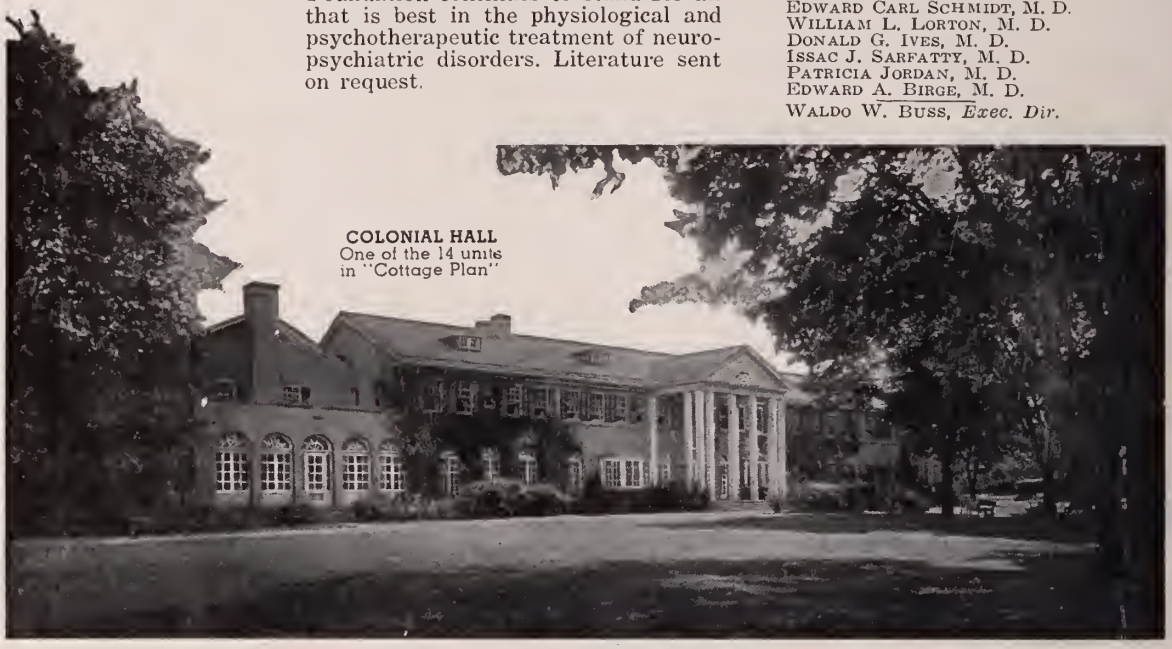

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Epidermoid Carcinoma of the Trachea

A Report of Five Cases

By WILLIAM M. PFEIFER, M. S., M. D.,* DANIEL MILLER, M. D., F. A. C. S.,** and HURLEY ROBINSON, M. D.***

Milwaukee Boston, Mass.
Santa Barbara, Calif.

BECAUSE tumors of the trachea are infrequent, it seemed worthwhile to record our experience with recent cases. No extensive historical review is contemplated since several good ones are available.

Culp[1] reviewed 433 primary tumors of the trachea on record in June, 1936, with emphasis on the pathology. Of these, 147, or 34%, were carcinoma and only 38, or 9%, were of the epidermoid variety. Zarowitz and Hoffman[2] reviewed the entire subject, stressed its rarity, and reported one autopsied case. They indicated that the total reported cases up to 1952 remained under 200. Gilbert, Mazzarella, and Feit[3] reviewed 546 cases of primary tracheal tumors in 1953 and found that in adults 194 were carcinomatous whereas the 4 malignant tumors in infants were sarcomatous. Moersch, Clagett and Ellis[4] reviewed the Mayo Clinic experience with 82 primary neoplasms of which 47 were considered malignant. There were 19 squamous cell carcinomas. The literature from Europe contains several reports of tracheal tumors. The majority of the malignancies are of the cylindromatous variety when the photomicrographs are reviewed.[5,6]

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*** Former Resident in Surgery, Milwaukee County General Hospital, Milwaukee, Wisconsin.

Pathology

The pathology of tracheal carcinoma may be stated as follows: (1) The majority of these tumors are found in the mid or lower third of the trachea; (2) epidermoid lesions are less common than cylindromas and are usually seen in the lower third where their differentiation from the common bronchogenic carcinoma may be difficult; (3) cylindromas are adenocarcinomas of mucous gland origin and are usually seen in the upper third.[7,8,9]

Diagnosis

It is unfortunate that most of the cases reported to date have been far-advanced when first diagnosed. If any salvage is to be realized the initial symptoms of cough, wheeze and respiratory distress must be investigated. Any or all of these call for direct laryngoscopy and bronchoscopy if the cause is not readily apparent.

Therapy

Principles of therapy have been gradual in their evolution and the following seem now in order: nothing short of a sleeve resection should be done, as a lesser procedure such as fulguration or window resection overlooks the lymphatic drainage of the trachea.

The latter has been demonstrated: the intrinsic channels course in the intercartilaginous spaces, draining into the laterotracheal (recurrent chain) and pretracheal nodes; thence to the cervical and mediastinal groups.[10] To be sure, an adequate re-

gional node dissection in the usual sense is impractical; but those of intercartilaginous spaces, the laterotracheal and pretracheal area, should be resected.

Cylindromas are slow-growing, radioresistant, locally invasive, late to metastasize, but especially difficult lesions because of their propensity for local recurrence. In common with their bronchogenic cousin, tracheal epidermoid lesions are best treated by early adequate excision. The latter includes the first echelon of lymphatic drainage.

Reconstruction

Methods of tracheal repair have been under study for some time and certain principles are established. Whenever feasible it is preferable to do an end-to-end anastomosis or direct tracheocutaneous suture.[11] When this cannot be accomplished, prostheses of inert plastic are the best substitute.[12] The experimental data for direct suture have been well documented by the University of Minnesota group.[13] They estimated that from one-fourth to one-third of the tracheal length in dogs can be safely excised with direct suture. The following report substantiated this thinking: a 43-year-old man whose cylindromatous lesion was in the vicinity of the fourth tracheal ring underwent a sleeve resection between the second and the seventh ring via the cervical approach with end-to-end suture. His postoperative course was satisfactory. Follow-up examination at six months revealed that he had gained 8 kg., was working, and free of disease.[14] The trachea has little regenerative powers; this finding along with methods of prosthetic repair have come from work done on 75 different dogs. The duration of this study was two and one-half years.[15] Urinary bladder mucosa has been suggested for the repair of tracheal defects; although a rigid conduit results, the clinical application seems remote.[16] There have been several reports where the stoma was made trans-sternally by tracheocutaneous suture or with a prosthetic extension.[17]

Case Presentations

A summary of cases seen at the Pondville Cancer Hospital since 1927 is presented in Table 1. All were males and were not admitted until their disease was advanced. Three were in their fourth decade. In each, except Case 5, treatment was either palliative or terminal care and they died of their disease. The histologic type of neoplasm was epidermoid carcinoma in three and cylindroma in two.

TABLE 1—PONDVILLE HOSPITAL CASES

Hospital Number	Age	Admitted	Location	Pathology	Died
1. A. K. 1749	51	11-14-29	Lower ⅓	Epidermoid Carcinoma	12-14-29
2. R. D. 16169	78	9- 9-39	Lower ⅓	Cylindroma	4-29-40
3. D. T. 22912	46	11- 2-44	Lower ⅓	Cylindroma	2- 1-48
4. H. S. 34625	44	12-16-53	Middle ⅓	Epidermoid Carcinoma	7-28-54
5. R. C. 35707	47	8-10-54	Upper ⅓	Epidermoid Carcinoma	--- ---

Case 1—(MCGH, #480256, M. H.)—A 60-year-old white male was admitted to Milwaukee County General Hospital July 11, 1955, with a two week history of progressive dyspnea and stridor. He also had a nonproductive cough. General examination was not remarkable except for the respiratory system: he coughed frequently, had inspiratory difficulty, and was cyanotic. But for the above mentioned items, physical examination was normal. The laboratory data were within normal limits, including a roentgenogram of the chest.

Direct laryngoscopy and bronchoscopy revealed a polypoid tumor of the upper trachea. A tracheostomy was performed through the second tracheal ring because of acute respiratory distress. Biopsy revealed squamous cell carcinoma. After careful preoperative preparation the patient was operated on August 12, 1955, by the senior author. Exploration was carried out through a generous transverse incision. Skin flaps were mobilized, including the platysma muscle, to expose the hyoid bone above and medial halves of the clavicles below. The tracheostomy tract was left attached to the larynx and trachea to allow an en-bloc resection. After the strap muscles had been divided below, the lesion was freely movable and deemed operable. (Fig. 1 and 2) A thoracic surgeon was present and we agreed it would not be necessary to excise the manubrium or to split the sternum. A standard wide-field laryngectomy (Schall technique) was done, resecting the first five tracheal rings and a subtotal right thyroid lobectomy. Immediate gross pathologic examination revealed an inadequate distal margin. Therefore an additional tracheal ring was removed. The remaining trachea was mobilized by blunt finger dis-

Fig. 1—Gross Specimen. The lesion is in the lower left corner. The tracheal ring separately resected is not shown.

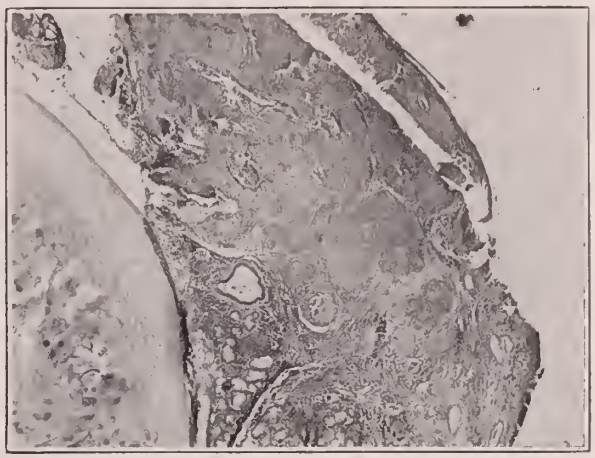

Fig. 2—Sheets of anaplastic squamous epithelial cells are seen in the upper half of the field with superficial ulceration of the respiratory epithelium which has a papillomatous arrangement in the lower left area of the photomicrograph. Hematoxylin and eosin X100. Case #480256, (S-3247-55).

section and sutured to the skin in the usual manner. Postoperatively he did well; feedings were started on the second postoperative day through a small lumen polyethylene nasogastric tube until a normal diet could be tolerated. The pathologic report stated that the tumor arose from the right posterolateral tracheal wall extending from the first to fourth rings. The additional tracheal ring separately removed was uninvolved as were the lymph nodes and thyroid gland. The patient was discharged in good condition on August 30, 1956. On the following day he developed acute respiratory obstruction at night and died suddenly. His physician stated that he had aspirated a clot. No autopsy was obtained.

Case 2—(MCGH, #474999, I. D.)—A 64-year-old white female was admitted to St. Michael's Hospital on January 12, 1955, because of coughing, choking, nervousness, and weight loss of two months duration. Workup was not remarkable except for a large goiter which extended substernally and a basal metabolic rate of plus 24%. She was discharged on antithyroid medication. On February 23, 1955, she reentered because of extreme dyspnea and stridor. Indirect laryngoscopy revealed partial paralysis of the right cord. On March 10, 1955, the thyroid was explored; the gland was found to be quite hard and adherent to the strap muscles; an abscess was entered in the lower pole of the left lobe. The latter was drained, right lobectomy and tracheostomy were done. On March 27, 1955, the left lobe was removed. The pathologic report was adenocarcinoma of the thyroid. The tracheostomy tube was removed and she was discharged April 9, 1955. On April 10, 1955, she had an episode of dyspnea with cyanosis, was readmitted, and a tracheostomy tube inserted. Bronchoscopy revealed no cord paralysis or obstructing lesion of the larynx. The left tracheal wall below the tracheostomy site was covered with granulation tissue. Biopsy was reported as anaplastic carcinoma. The patient was transferred to Milwaukee County General Hospital for further care and irradiation therapy.

Examination on April 28, 1955, revealed an elderly cachectic white female. No masses were noted in the neck, nor was there respiratory distress. Laboratory studies were normal. Bronchoscopy demonstrated paralysis of the right cord and a lesion on the left anterior surface of the mid trachea. Biopsy revealed squamous cell carcinoma. Palliative x-ray therapy was instituted. The patient's course was progressively downhill, and she expired May 12, 1955. Autopsy revealed an infiltrating squamous carcinoma of the an-

Fig. 3—Gross specimen. The lesion occupies the middle third of the trachea.

terior wall of the mid portion of the trachea with extension to the thyroid region. There were also metastases in the tracheobronchial and cervical lymph nodes. Slide-review of the thyroid tissue removed originally revealed infiltrating squamous cell carcinoma. This was interpreted as being metastatic from a primary lesion of the trachea. (Fig. 3 and 4)

Case 3—(PH, #35707, R. C.)—A 47-year-old man was admitted to Pondville Hospital, August 10, 1954, with a proved epidermoid carcinoma, grade 2, of the upper trachea. His history revealed a persistent dry hacking cough, wheezing, and progressive dyspnea of three months duration. He had been a heavy cigarette smoker for over 20 years. Indirect laryngoscopy demonstrated an extensive outcropping of grey tumor below the vocal cords. No nodes were palpable in the neck. A tracheostomy was done August 17, 1954, to provide an adequate airway and to facilitate bronchoscopy. The latter was done August 20, 1954, and radical resection appeared

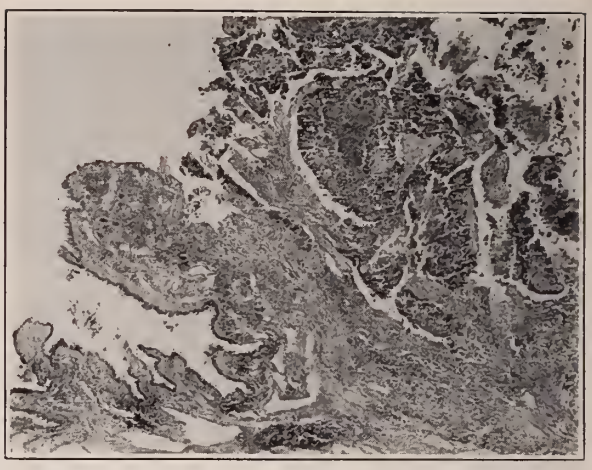

Fig. 4—This field with nests and sheets of anaplastic squamous epithelial cells shows an area near the center of the lesion. An associated lymphocytic infiltration is noted near the lower border of the photomicrograph. Hematoxylin and eosin X100. Case #474999 (A-276-55).

feasible. He was transferred to Massachusetts Eye and Ear Infirmary for this procedure and it was done under the supervision of the junior author September 18, 1954. It included a wide field laryngectomy, upper trachectomy (five rings), and right subtotal thyroidectomy. His postoperative course was uneventful.

The pathologic report was squamous cell carcinoma, grade 3. The lower border of the specimen was clear of tumor as was the thyroid gland.

Since surgery, he has done well. A mass appeared above the stoma in May, 1956, but this disappeared spontaneously within two weeks. He was last seen February, 1957, at which time there was no evidence of disease.

Conclusions

1. A brief review of tracheal tumors is presented.
2. Carcinoma of the trachea is uncommon and the epidermoid type accounts for roughly 35% of those on record.
3. Early diagnosis is essential if more patients are to be salvaged.
4. Five cases of epidermoid carcinoma of the trachea are reported (three in detail) and the principles of therapy are discussed.

(W.M.P.) 425 East Wisconsin Avenue.

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PREPARATION OF MANUSCRIPTS FOR THE WISCONSIN MEDICAL JOURNAL

Exclusive Publication: Articles are accepted for publication on condition that they are contributed solely to this Journal. Publication elsewhere will be subsequently authorized in the discretion of the Medical Editor.

Correspondence: Address all correspondence relating to publication of scientific papers to the Medical Editor, Box 1109, Madison 1, Wisconsin.

Manuscript: Type double spaced, on 20 pound white paper, 8½ by 11 with one inch margins at the top, bottom, and right, and 1½ inches on the left. Submit the original and two carbon copies. Use the metric system throughout. Call drugs by their generic names. The trade names can be added, in parenthesis, if they are considered important. Keep one copy of the paper.

Identification: Place the name of author and page number at the upper left-hand corner of each page except the first.

Footnotes and References: Use the style of the *Quarterly Cumulative Index Medicus* published by the American Medical Association, which requires, in the order given: name of author, title of article, name of periodical, with volume, pages, month—day of month if weekly—and year as follows:

4. Doe, J. E.: What I know about it,
Wis. Med. J. 54:717–719 (Dec.) 1954.

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Under ordinary circumstances articles are scheduled about six months in advance. The approximate date of publication, subject to change, will be given the contributor when the article has been accepted.

Society members throughout the state are encouraged to write up their interesting cases and submit them for publication. The editorial staff welcomes the opportunity of helping you prepare your article for the printer.

PROGRESS WITH RADIOISOTOPES IN MEDICAL RESEARCH

Medical research continues to benefit profoundly from the availability of radioisotopes. The ability to follow dynamic, complex and submicroscopic body processes, coupled with extreme sensitivity of measurement, makes isotopes invaluable tools for life science studies. Routine diagnostic tests and new methods for treatment are outgrowths of this research.

Progress in the medical use of radioisotopes in the United States is perhaps best reflected by the creation in 1957 of a national Society of Nuclear Medicine. This society already has over 1,000 members and its annual meetings reveal continuous progress in medical research and clinical applications. A further indication of progress is the decision of the American Board of Radiology to require qualification in nuclear medicine as a prerequisite for certification in radiology.

Several reviews of progress in nuclear medicine appear yearly. These reviews demonstrate increasing successful use of radioisotopes in diagnosis and treatment of thyroid disease, treatment of cardiac disease, measurement of blood and plasma volume, determination of cardiac output and circulation times, study of rate of production and average life of red blood cells, diagnosis of pernicious anemia with radiocobalt labeled Vitamin B_{12}, localization of brain tumors, and many other uses.

Out of this vast area I wish to select a few examples that hold forth hope of important extensions in clinical applications. Iodine–131 still is the most important single isotope in terms of the very large number of patients involved and the expanding number of using physicians, hospitals, and clinics. Although I^{131}, which decays with an 8-day half-life, has proved satisfactory, there are applications that may be better served with a shorter half-life isotope. An ideal diagnostic tool would be one that reveals the desired information quickly and then rapidly disappears from the metabolic pool. Twenty-five minute iodine-128 may approach these requirements. Use of I^{128} would substantially reduce exposures in thyroid uptake and other diagnostic studies. The supply problem has greatly hampered use of this radioisotope. However, installation of research reactors throughout the United States will make I^{128} routinely available along with other short-lived radiosotopes of high specific activity. Development of the Szilard–Chalmers process for enhancing the specific activity of reactor-produced radioisotopes holds promise of making small, inexpensive reactors valuable producers of very useful, short half-life radioisotopes.

Strontium–85, a 65 day half-life, gamma emitter is showing promising results in the study of bone diseases. Since this isotope may be detected externally, the continuous rate of uptake, total activity and retention of strontium may be readily measured. This should permit differentiation between normal and and diseased states of bone.

A startling radioisotope technique has recently been devised to diagnose defects within the heart. By measuring the activity of blood samples taken from heart cavities, following inhalation of krypton-85 gas, the location and approximate size of any defects may be determined. This technique is remarkably successful in determining, without the risk of exploratory operations, types of heart malformations and necessary corrective measures.

Teletherapy devices continue to be a major medical use of radioactivity. Over 160 cobalt-60 units in the United States, at an average of 1,000 curies each, make teletherapy devices a sizeable portion of the whole demand for radioisotope production. Cesium-137 is coming to the fore as an alternate source of clinical radiation energy. Several kilocurie cesium-137 teletherapy units are now being tested. Cesium-137 has the skin sparing and depth dose advantages of supervoltage radiation, comparable to an X-ray machine operating at 1 Mev. With the very large quantities of cesium-137 now available it should play an increasingly significant role in radiation therapy.—**Prepared by Dr. Willard F. Libby, Commissioner United States Atomic Energy Commission and delivered before the Second United Nations International Conference on the Peaceful Uses of Atomic Energy, Geneva, Switzerland, September 3, 1958.**

The Milwaukee Academy of Medicine—The Early Years*

By HOWARD J. LEE, M. D.
Milwaukee

TONIGHT the Milwaukee Academy of Medicine enters its seventy-third year. We are meeting for the nine hundred and twenty-ninth time.

Several years ago, as librarian of the Academy, I became interested in the detailed longhand minutes of the early meetings. These minutes have been edited to present some of the highlights of the years preceding 1905.

We shall meet many physicians, some teachers, and some friends. Many of you are related by more than interest to these physicians. Some who are a part of that period of which we shall speak are still among us. I would like to pay particular respect to my teacher, Dr. Otto H. Foerster, one of the actors in tonight's story, who has listened to and been listened to concerning these events. "The Medical History of Milwaukee, 1834–1914" by Dr. Louis F. Frank has been a basic source of material.

Our Academy was formed by Drs. James Dorland, A. B. Farnham, Louis F. Frank, Samuel French, Robert Hawley, Henry Ogden, F. Walbridge, and William Washburn on Tuesday evening, January 12, 1886, as the "Clinical Club." From the first, the meetings were preceded by a dinner. A repetition of one was our menu tonight. Others would be too difficult as they included roast bear, or antelope steak, canvasback, or snipe. Conviviality aided by food and drink, together with interest in medicine, have combined to preserve this organization's continuity.

In 1882 the name was changed to "The Bartlett Clinical Club" honoring Dr. J. K. Bartlett, who had made several prior attempts to form a group. In January, 1891, we became the Milwaukee Clinical Society, and later The Milwaukee Medical Society. The present name is not used in the period of tonight's story.

We maintain lineal descent from these organizations, but because we had a library we have preserved the records of prior medical groups of Milwaukee. We claim no relationship to these, but for interest and orientation it may be well to explore their minutes.

Milwaukee was permanently settled in 1835. The description of the city by an anonymous French physician in 1843 is in order. I quote in part, "the penury and distress of the country at large is great and on the increase. Farming is a losing concern on these large, so much boasted of prairies, produce don't pay at all in proportion to expenses. Farmers complain bitterly, many get ruined, move off going to Oregon or Florida to act over the same farce again and again.

"A great number of laborers from the old country go now here without employment, what will it then not be in winter? This city has about 7,000 inhabitants, 280 of whom are merchants and retailers with open stores and shops of every description. Business is dull, money scarce, all on trust and perhaps never payment.

"Religious bigotry and fanaticism here have reached their zenith, or more truly their nadir. The Bible and nothing but the Bible is the all absorbing topic of conversation.

"Most of the laborers and servants are Norwegians and Catholic Germans, whose language is considered a kind of gibberish. The self conceit of these Yankeys, and their high estimate of themselves is truly shocking, and passing all decency.—

"I forsee and predict that you can never choose this country for your second home, no you cannot, since unhappily, as I know, your education has wholly spoiled and uprooted your taste for a semibarbarous state of life."

The Milwaukee Medical Association was formed December 9, 1847. The constitution stated that the "object of this Association was to protect the interest and to promote the advancement of medical and collateral sciences." Rules of etiquette, by-laws, and, of course, a fee bill were established. From the latter:

* Presented at the annual meeting of the Milwaukee Academy of Medicine, January, 1958.

Ordinary office prescription	$ .50
Venesection, extracting a tooth, each	.50
Opening an abscess	.50
Letter of advice	2.00–5.00
Ordinary visits	1.00
Night visits (after 10 PM)	2.00
Obstetrical attendance	
(Not exceeding 24 hours)	10.00
(Twin Cases)	15.00
Gonorrhea—in advance	5.00
Syphilis—in advance	10.00

One will note that the cost for treatment of sin was graduated, or may we infer that there were degrees of misfortune.

This Association asked the Common Council to pass an ordinance requiring that sextons, and others engaged in burying the dead, furnish an annual bill of mortality and recommended that a physician be appointed to the Board of Health. They directed a circular to the prominent druggists in the city to abandon the traffic in quack medicines.

The Medical Association agreed to attend the poor in the Alms House, the Pest House, and the wards of the city in every pauper case for $600.00 annually.

In July, 1848, Doctor Spaulding related the first clinical problem. A laboring man had suffered for six months from two fistulous openings on each side of the epigastrium. These extended several inches beneath the skin and cellular tissue. Various remedies, non-homeopathic, had been applied, including injections of silver nitrate, fomentations of bread and milk, warm fresh beef, and the liver of a freshly killed mutton. Excision with a knife had been resorted to in vain. The patient became worse and suffered at times the most excruciating pain, restlessness, and emaciation. At length, Doctor Spaulding stated he was induced to try the suggestion of "a learned physician of The Emerald Isle," the application of a warm puppy. Accordingly, an animal was decollated, and then split through the spine and applied at blood heat. This application was soon followed by the most intense pain. When it was removed forty worms, varying in lengths from one half to three inches, perfectly white and round were found adhering to, and greedily devouring the canine morsel. The second, third, and fourth applications of this dry poultice were followed by similar results so that 83 worms in all were removed. By this treatment, alike novel and curious, the patient was quite restored to health.

In January, 1849, Milwaukee, a town of 20,000 people and 13 physicians, was devasted by Asiatic cholera. This epidemic had originated in New Orleans, spread to Buffalo whence it came to Milwaukee by boat vectors. The Association deliberated at length about this disease, recognizing that they were confronted with an overwhelming problem. They met it by passing, unanimously, the following: "Resolved that no fact in medicine, in the opinion of this Association is more clearly determined than that the Asiatic cholera was not a contagious disease, and any action on the part of the authorities which is based upon the supposition that it is so, and it subjects the sick to any inconvenience therefore, is clearly unwarranted, and inhuman, and will not receive the sanction of the members." Recall that Snow of London incriminated contaminated water as a source of this disease in 1854. The vibrio was described by Koch in 1883 but not proven to be the etiologic agent until the work of Pfeiffer in 1893.

In January, 1856, a paper was read on the puerperal convulsions. One physician spoke against bleeding, believing the malady to be nervous in character. He advocated, the expected plan, stating that the appearance of the "little expected" usually put an end to the convulsions. Another physician cited one case in which heroic Antiphlogistine treatment proved successful. Doctor Wolcott reported a case in which convulsions were frequent. He decided to let Nature take her course, labor progressed, the woman delivered, and the convulsions ceased.

The Society resolved to subscribe for some standard medical journals. In June, 1856, it is recorded that lager flowed, much to the gratification of all. Doctor Wolcott suggested that in the future "we do away with present custom as regards to refreshment, by meeting in the respective offices, and adjourning to the lager beer halls." At the subsequent meetings when there was no quorum they adjourned to convene in a lager beer hall.

Medical School Plans

In June, 1869, this group conferred with a Regent of the University of Wisconsin, Edward Sullivan, concerning the establishment in Milwaukee of a Medical College whose degree would be conferred by the University. The appointed committee reported that after careful consideration of the subject, and after ascertaining how much assistance could be expected from the business men and capitalists of the city, any present action would be premature.

The Association considered it their duty to assist in the enforcement of the law requiring the vaccination of every infant between the ages of three and seven months by some respectable physician who should give the parents a certificate attesting that the child had had genuine vaccinia.

In 1877, Doctor Ladd read a paper on scarlatina. He stated that this was a disease which was carried from a sick patient to a well person by unknown means. He believed the poison was generated or carried in the blood, or in the dejections. He noted that there was great difference in the susceptibility of people to take this disease. Whole families remained free from it. He observed that children rarely had it before their sixth month and that most cases occurred in children between the ages of two and seven. Susceptibility began to diminish after the tenth year. The specific, which contained the poison, could be transferred in clothing, furniture, and other articles. He regarded the prognosis to be unfavorable and believed the mortality to be from fifteen to twenty per cent. No prophylaxis had been discovered. He advocated symptomatic treatment. The skin should aid the kidneys to eliminate fluid. The patient was to be kept quiet. He recommended astringent gargles for the throat and spirits of nitre, potassium tartrate, and quinine to depress the temperature. A colleague remarked that he treated his cases by the application of fat to the skin. He also used cream of tartar and digitalis. All cases complicated by convulsions should be bled. Another urged the use of carbonate of soda to prevent sudden death due to formation of clots in the blood vessels and the heart. He favored the use of ammonia to prevent the formation of fibrin, giving four to five drops of ammonia water well diluted, but taken often.

During this period recent surgical specimens were brought to the meetings. Surgical techniques were discussed at length.

This is our heritage prior to the advent of The Clinical Club on January 12, 1886.

At the first meeting, Doctor French narrated the story of a 28-year-old woman who had noticed an abnormality on the right side of her abdomen. A tumor was detected in the pelvis. At operation, cystic degeneration of both ovaries was observed and they were removed. The operation took only three and one- half hours. Convalescence though slow, was uninterrupted. The patient's temperature never rose above 100 degrees. She was in the hospital only five weeks.

Doctor Ogden outlined the pathologic differences between diphtheritic and membranous croup. He stated that the one was a microbial disease and the other a vasomotor reaction from a cold which appeared in the larynx and elsewhere as might microbic diphtheria. Microbic diphtheria was a communicable disease, non-microbic diphtheria or diphtheria from cold was not. Microscopic examination of the membrane offered no basis for the differentiation, but the temperature and general symptoms were more marked in microbial diphtheria.

Doctor Copeland, in 1887, reported that a newborn child after five weeks of incessant crying stopped instantly when given a pickle, which the mother had craved during her pregnancy. Dr. Horace Manchester Brown reported the dislocation of a ninth costal cartilage from too tight lacing of the corset.

Many Sources of Infections

In December, 1889, "The Prophylaxis of Puerperal Fever" was discussed. Doctor French stated that for many years he had endeavored to be aseptic. Doctor Wingate, who had never had a fatal case in his own practice, believed there were so many sources of infection that he would not hastily blame a colleague. Doctor Frank urged that few examinations be made since the virus of septicemia was always induced from without. Doctor Washburn remarked that he had confined 450 women and the only precaution he took was to wash his hands carefully. Doctor Nolte thought one should have a special suit of clothes for obstetrics. Doctor Copeland asserted that it was all but impossible to obtain asepsis due to the habit of many nurses and patients of making frequent pelvic examinations. He said that he used only soap and water on his hands. Doctor Batchelor reported a case which occurred in the same home where there were cases of scarlet fever. Doctor Brown described a patient who contracted the disease from the mattress on which another woman had died of puerperal sepsis two years previously.

Utilizing the $40.00 dues, in May, 1890, the publications of the New Sydenham Society were purchased. These volumes remain in the historical collection of the Academy, as a memorial to Dr. A. W. Gray.

In mid-June, Doctor Wuerdemann dis-

cussed hysterical aphonia and remarked that though some cases might have a local cause, usually a condition of the mind was present, and this had to be removed to effect cure. He cited a case where a blister applied behind the ear was effective treatment. Doctor Brown passed thermo-cautery down the spine to cure these cases. He found that prostitutes often had this trouble, and he treated them by the vigorous use of electricity. Doctor Farnham thought that the impression made upon the nervous system was very important, This impression might be made by such things as a shower bath.

Later in the year, Doctor Ogden reported a case of malignant scarlet fever in which the temperature reached 110 F. or more. He reduced it to 106 F. by a bath, but convulsions followed and death occurred in a short time. A discussion of the treatment of scarlet fever resulted and the opinion was left that no known treatment was of value.

A month later Doctor French read a paper "Drugs, What are They Good For." This provoked many remarks. All members participated and various experiences and views were exchanged. Several doubted the value of drugs, while others expressed great confidence in their use. If the Harry Beckman of today had entered the meeting, the group would have believed him to be from outer space.

Doctor Nicholas Senn requested a contribution to a fund honoring Doctor Virchow's seventieth birthday. The Society donated 100 marks. Later Doctor Puls, discussing displacement of the uterus, stated that man had been subjected to more suffering and ailment of his body because of his upright position than any other living animal. Doctor Clark reported prolapsus in a young girl who was cured of the condition by tampons of iodized sea moss.

No Smoking at Meetings

May 18, 1891, a resolution was passed and adopted as follows: "Whereas it is not considered good custom at any assembly to smoke during its sessions. Whereas some members dislike the effect of smoke at the sessions. Whereas it is proposed to admit lady members to this Society. It is, therefore, resolved that no smoking shall be allowed during any of the regular or special meetings of this Society or at its Council. It is further resolved that it shall be the duty of the presiding officer to call any person to order who may violate any part or parts of this resolution." To be kind to those who are hastening their pulmonary emphysema by this foul habit, this officer shall not enforce this resolution in 1958.

During 1891, diphtheria was discussed frequently. Persistence of infection in the tonsil follicles was debated. The local treatment of the tonsil was stressed. Some suggested discharges from the ear after scarlet fever might cause diphtheria. The carelessness of people in discarding rags and clothing was regarded to be the commonest cause of contagion. Doctor Copeland stated that he did not see how one could use antiseptics as one did not know what a germ was or what would kill it. He believed diphtheria to be constitutional and not local. Doctor Ogden and Doctor Dorland concurred. Doctor Burgess inquired whether the hammer headed bacillus was regarded to be the cause of diphtheria.

Doctor Batchelor believed it impossible to eradicate diphtheria in a city with sewerage, though he recognized that the difficulties were just as great in a district without sewers. He believed that the sewers of every large city contained the germs of diphtheria at all times. He recommended isolation of germs in a house, so that fewer could get into the sewers, thereby reducing the chance of an epidemic. Doctor Washburn declared that there was no evidence that there were any germs in the sewers of Milwaukee. He believed that scarlet fever or diphtheria was rare in houses with inside sewer connections. Recall that Klebs discovered the diphtheria bacillus in 1883. The etiologic relationship to the disease was established by Loeffler in 1884. The year of this discussion, Von Behring was using his first anti-serum on patients. Dr. Horace Manchester Brown in discussing the above said that he was getting to be an old man, and that he was fast seeing the legs of so-called medical science giving away. He thought it was high time for doctors to stop their talk about the great work of the medical profession.

In 1891, it was announced that Professor Birge of the University of Wisconsin would deliver a course of lectures on bacteriology in this city.

In January, 1892, Dr. W. H. Washburn urged vaccination. Discussion centered about ways to meet thrusts of the Anti-vaccination Society. Doctor Brown noted that opposition to vaccination usually came from "long

haired men and short haired women, and people who wear cloth gaiters and from Harry Danforth and from other small boys in the papers." "Harry Danforth" is not identified further. Doctor Brown continued "that it seemed to him that the opposition was bound to die of inanition in a short time. The cranks who oppose vaccination belong to the class of incomprehensible blockheads who will not be convinced." He thought it was useless for the Society to attempt to educate them.

Doctor Wingate regarded the cheap performance of vaccination worthy of criticism. He believed that many physicians took no interest in the results. He deplored that it was customary to vaccinate for between 10¢ and $1.00. He maintained that successful vaccination was worth $5.00.

Doctor Washburn described experiments which had been performed to determine whether syphilis could be transmitted by vaccination. He told of a physician, an enthusiast on the subject, who had vaccinated himself repeatedly from children known to be syphilitic. For years the results were negative. Finally, "he struck a young one that was fairly loathesome, rotten with the disease." Vaccination with virus from that child produced syphilis. He was then satisfied. Doctor Washburn believed it was dangerous, unwarranted, unjustifiable, and a criminal procedure to use a syphilitic child as source of the vaccine.

In March, the members further discussed their experiences with syphilis. Whether fathers having syphilis could produce a syphilitic child without the disease becoming evident in the mother was argued. The merits of mercury and the iodides were detailed. The final remark of the evening by Doctor Wingate was, "that goes to show undoubtedly that in a good many constitutions, syphilis is uncurable; while in others it is very easily curable, perhaps."

May 10, 1892, Doctor Washburn discussed post partum hemorrhage, and the events which followed a prolonged and difficult labor. He had been the consulting physician, and while in the kitchen resuscitating the child, he heard the physician in attendance call, so frightened that he could not tell him why he wanted him. Doctor Washburn rushed to the bedroom. The woman exclaimed, "for God's sake, Doctor Washburn don't let me bleed to death." "Certainly," he states, "she would have bled to death in a very few minutes, for when he turned back the bed clothes there was a stream of blood coming from her as large as two fingers." At once he introduced his left hand into the uterus and made pressure over the abdominal wall with his right hand. He dispatched her husband for a piece of ice which was thrust into the uterine cavity. The irritation of the hand caused a strong uterine contraction, and immediately after the introduction of the ice, the hemorrhage ceased, and did not recur. The woman made a good recovery. Doctor Puls in a less dramatic manner advised the use of iodoform gauze packing.

On May 24, 1892, Dr. F. J. Tower read a paper on the "Etiology and Bacteriology of Diphtheria." Doctor French reported the failure of injections of chlorine water in the treatment. He stated that there was considerable diphtheria in Milwaukee. About 400 cases had occurred in 1891. He believed that many cases of diphtheria reported were not diphtheria. The Klebs-Loeffler bacillus remained unrecognized in Milwaukee.

A.M.A. Meeting in Milwaukee

Through 1892 preparations were made for the meeting of The American Medical Association to be held in Milwaukee in June, 1893. A large attendance was expected because of The Columbian Exposition to be held in Chicago. With this added attraction, physicians were expected to bring their wives to the meeting. There were only 18 members of the A.M.A. in Milwaukee. It was urged that the members of the Society become members of The State Medical Society so that they could qualify for membership. The dues were $5.00 and entitled the member to the Journal of the American Medical Association.

Doctor Washburn advocated specific treatment of typhoid fever. He believed the so-called "expectant" treatment to be no treatment at all. The patient alone received the treatment, the disease remained untreated. Doctor Schiminek proposed treating the disease by attacking the bacillus in the intestinal canal using beta naphthol. Dr. Henry Hitz, a guest, remarked that at the Philadelphia Hospital the specific treatment of typhoid fever consisted of the injection of 30 cc. of serum from a convalescent patient. He stated that if this were given in the second week the temperature would fall to

normal in two days and great benefit would result.

We enter a surgical era. The development of surgical technique hastened exploration. Members vied in displaying their surgical pathologic specimens.

Dr. Horace Manchester Brown discussing a paper on thyroidectomy, stated that "it was certain that within our time, or in the time of most of us, it has been said that to perform a thyroidectomy was simply to cut the patient's throat. No doubt, the reasons for that statement were well grounded inasmuch as before the days of antiseptic surgery, it was simply a matter of chance whether the patients recovered or not from the operation." Doctor Brown recalled that Port of Milan, in 1847, advocated enucleation of the cystic tumors of the thyroid body, without removal of the glandular tissue. Jaques Reverdin in 1882 had suggested that the postoperative cachexia strumipriva, which followed a number of cases operated by his brother, August, were due to complete removal of the thyroid body. In 1883 Kocher of Berne had aroused the attention of surgeons in Germany to the fact that this cachexia strumipriva was dependent upon the removal of the thyroid body. Doctor Brown mentioned a great many other things that had been tried in the treatment of goiter. The use of iodine has been suggested by some, but it was objectionable because of the extremely disagreeable odor and taste. Other men had used iodoform in pills. He mentioned that operations performed on cases treated by iodoform showed that the action of the iodoform was to diminish the size of the tumor. He believed the action of iodine was not on the cyst in the gland nor upon the fibroid degeneration in the gland, but rather on the normal gland tissue. He argued that treatment with iodine diminishing the normal tissue was not appropriate as it did not diminish the cystic or degenerated tissue. Doctor Burgess reported cases of "old goiter" which had become subject to cancerous degeneration, and remarked that a professor of surgery of large experience warned his students to carefully examine a goiter which had existed for a long time. He urged examination of the glands of the neck for though there might be no evidence of cancerous degeneration of the thyroid, it might be found in a gland. Doctor Bach remarked that Professor Parks habitually injected the cystic tumors of the thyroid with a 5% solution of carbolic acid in glycerin. He spoke highly of the results of this procedure.

In February, 1893, Dr. Horace Manchester Brown objected to the time required to fill out insurance reports.

A month later, Dr. M. H. Clark read a paper on angina pectoris. He believed the pain to be due to ischemia of the heart itself, and that degeneration or obstruction of the coronary artery was the primary cause. As a result of this change, the heart was improperly supplied with blood.

In April, Doctor Schiller discussed a paper by Doctor Frank on drug exanthem. He stated he had recently seen a patient who had extensive eczema of the face, neck, and shoulders. This immediately followed the ingestion of canned salmon. He believed the lesions were due to an irritation produced in the stomach by the impure or decomposed salmon. Thus, in the first mention of what may have been an allergic reaction, the preserving process was blamed. The reaction was observed, but the word "allergy" had not been coined.

Antitoxin Treatment

In December, 1895, the antitoxin treatment of diphtheria was discussed. The author viewed the present antitoxin craze and felt it would follow the wake of Brown-Sequard's elixir of life and Koch's lymph.

In June, 1896, Dr. Arthur J. Patek, a guest of the Society, read a paper on the clinical importance of hematology. He outlined the clinical significance of various pathological conditions of the blood and reviewed the technique of examination. This paper was discussed with appreciation by Doctors Hitz, Brown, and Washburn. A year later Doctor Patek read a paper on the Widal test.

Finally, in June, 1897, Doctor Hay reviewed the antitoxin treatment of diphtheria and reported his experience with the remedy. He unqualifiedly favored its use in all cases of diphtheria.

On March 28, 1899, Dr. Ludwig Hektoen of Chicago delivered an illustrated lecture upon the pathologic blastomyces. He described blastomycosis, a disease new to members of the Society. Through the rest of this year the meetings became more clinical and it became the custom to have a guest speaker from outside the city.

In January, 1900, Dr. W. A. Evans of Chicago stressed the infectiousness of milk from tuberculous cows. Dr. Horace Manchester Brown read a paper entitled "Our Merited Inheritance." He criticized members of the medical profession for their lack of business ability and gentlemanly self esteem. He pointed out that as a consequence the profession was not looked upon by the public with the respect shown to the legal and other professions.

April, 1901, Dr. Paul Thorndike of Boston discussed surgery of the prostate. This was reported to be the most interesting discussion on this subject ever presented. In October, Dr. F. G. Novy of Ann Arbor gave a very complete description of the origin and spread of bubonic plague, including his personal experiences as a member of the Commission appointed by the President.

February, 1902, Dr. Frank Billings of Chicago discussed clinical observations of the early stages of cirrhosis of the liver. At the meeting of November 25, 1902, guests included were Drs. J. D. Madison and Otto H. Foerster.

In 1903 there were 119 active, 8 active non-resident, and 9 honorary members. Seventeen meetings had been held during the year, plus a smoker for the Wisconsin Medical Society. An informal reception was held for Dr. William Osler, who had come to see a patient in consultation with his classmate, Dr. Henry Ogden.

On June 14, 1904, Dr. Otto Foerster reported the details of a case of dermatitis venenata due to the primrose, a rare cause of dermatitis as there had been only a dozen cases recorded in America.

February 28, 1905, Dr. Charles R. Bardeen of the University of Wisconsin presented, by invitation, "Certain New Aspects of Anatomy." October 10, 1905, Dr. Otto Foerster demonstrated a specimen slide of Spirochaeta pallida which he stated was believed to be the causative factor of syphilis.

Here we have elected to stop our wanderings. We could continue for hours. The original sources remain in the Academy library, and in longer and original form can provide interesting moments for any of you.

425 East Wisconsin Avenue.

BOOKLET PUBLISHED FOR FAMILIES OF STROKE PATIENTS

A new booklet, entitled "Strokes, A Guide for the Family," has been published by the American Heart Association and its affiliates, according to an announcement by Dr. Robert A. Frisch, president of the Wisconsin Heart Association.

As the title indicates, it was prepared primarily for those who live with or care for the stroke patient. Copies of this booklet are available from the Wisconsin Heart Association, 441 West North Avenue, Milwaukee 12, and may be requested by physicians to give to the families of such patients. Copies may also be obtained by nurses, physical therapists, speech therapists and others concerned with the rehabilitation problems of stroke sufferers.

The booklet emphasizes the importance of early rehabilitation and of close cooperation between the physician and members of the family in helping stroke patients regain many of their abilities. It gives specific suggestions for self-help devices that can be used at home and also lists a number of sources through which additional help may be sought during the rehabilitation process. Also included are recommendations for the families of patients requiring treatment over a long period of time and a discussion of the special problems of the patient with aphasia.

State Medical Society Postgraduate Courses

CIRCUIT TEACHING PROGRAM IN MADISON OCTOBER 29

A circuit teaching program will be conducted Wednesday afternoon, October 29, at Wisconsin General Hospital, Room 300, Madison. Subjects to be discussed are:

RECOGNITION OF VARIOUS CARDIAC MURMURS, by George Rowe, M.D., Assistant Professor of Medicine, University of Wisconsin Medical School. This presentation (1 hour in length) will consist of a combined lecture and demonstration, with use of the Cardioscope, furnished by the University of Wisconsin Medical School through funds of the Wisconsin Heart Association. Because the room used is wired so that exactly 100 physicians can participate in this demonstration attendance must be limited to that number.

THE ACUTE SURGICAL ABDOMEN IN CHILDREN, by Tague Chisholm, M.D., Clinical Assistant Professor of Surgery, University of Minnesota Medical School, Minneapolis. Doctor Chisholm will discuss this common surgical problem by way of differentiating diagnosis, and touch upon the related subjects of appendicitis, intussusception, Meckel's Diverticulum, ulcers (bleeding), and intestinal obstruction.

THE EPIDEMIOLOGY OF VIRAL INFECTIONS OF THE CENTRAL NERVOUS SYSTEM (Aseptic Meningitis), by H. Kleinman, M.D., Chief, Section of Chronic Diseases, State of Minnesota Department of Health, Minneapolis. Recent advances in Virology have enabled medical researchers to more clearly define certain groups of diseases hitherto classified as "aseptic meningitis of unknown origin." The speaker will review recent experiences in Minnesota, with the aspetic meningitis syndrome in which the predominant causal agent was different each year. This experience will be reviewed from the clinical and epidemiological standpoints in order to see how this knowledge can be of value to the physician in private practice. The newer implied responsibilities of physicians in practice, and of health departments, will be discussed.

PITFALLS IN GASTROINTESTINAL DIAGNOSIS, by M.C.F. Lindert, M.D., Associate Clinical Professor of Medicine, Marquette University School of Medicine. There is an apparent drifting from "between-the-ears reasoning" to "between-the-labs reports" in the diagnostic acumen of gastrointestinal diseases. Complete acceptance of radiologic reports and a lack of understanding of special, ever-increasing laboratory tests may place the physician in an embarrassing situation. This confusion of diagnostic adjuncts plus failure of correlation with the ever basic historical and clinical features has yielded erroneous and at times catastrophic diagnoses. Fundamental approaches to gastroenterological problems along with case illustrations will be presented.

Reservations are to be made in advance. Fee $5.00. Make checks payable to: State Medical Society of Wisconsin. Mail to: Box 1109, Madison 1, Wisconsin.

CIRCUIT TEACHING PROGRAM AT STEVENS POINT NOVEMBER 20

A circuit teaching program will be conducted Thursday afternoon, November 20, in Hardware Mutuals Auditorium at Stevens Point. Subjects to be presented are:

FEVERS OF UNKNOWN ORIGIN, by Samuel Rosenthal, M.D., Assistant Clinical Professor of Medicine, Marquette University School of Medicine. Doctor Ruch will cover Acne Vulgaris, Bacterial Infections of the Skin, Fungus Infections of the Skin, Contact Dermatitis, Benign and Malignant Conditions of the Skin, Atopic and Seborrheic Eczema and Papulo–Squamous Lesions of the Skin. Both diagnosis and treatment will be presented.

OVARIAN TUMORS, by Jack Klieger, M.D., Assistant Clinical Professor of Obstetrics and Gynecology, Marquette University School of Medicine.

ALLERGIES IN CHILDREN, by Seymour B. Crepea, M.D., Associate Professor of Medicine, University of Wisconsin Medical School. Doctor Crepea will define clinical allergy and the general background of the patient, present clinical diagnostic methods of evaluation of common causes of allergy (inhalants, ingestants, and infection), and present general methods of management.

Because this meeting will end at 6:00 p.m. the last hour will be devoted to a question and answer period, covering the material presented by the four speakers.

Reservations are to be made in advance. Fee $5.00. Make checks payable to: State Medical Society of Wisconsin. Mail to: Box 1109, Madison 1, Wisconsin.

Surgical Experiences with Pulmonary Coin Lesions*

By OTTO V. HIBMA, M. D., and EDWARD I. BOLDON, M. D.
Madison

SURGEONS who undertake the treatment of pulmonary coin lesions find themselves in general agreement that all, or nearly all, such lesions should be routinely excised because of the possibility the lesion may be cancer. If there is still disagreement, it centers about the proper course to follow in those lesions which show some calcification, a finding which in the past has been considered evidence of a benign process.

A pulmonary coin lesion is defined as a solitary, rounded density as seen on x-ray, lying within the lung parenchyma, and without obvious origin from mediastinum, diaphragm, or chest wall.[1] Figure 1 shows a typical example, and lists the usual criteria.

Fig. 1—X-ray criteria—coin lesion: (1) less than 6 cm., (2) solitary, (3) appears to be intrapulmonary, (4) round or ovoid, (5) margins reasonably sharp, (6) no atelectasis or pneumonitis.

Many have belabored the term "coin lesion," and would prefer to say "isolated pulmonary nodule," "circumscribed solitary lung lesion," "solitary circumscribed intrathoracic radiopacities," etc.[1] It would seem that the term coin lesion benefits from its simplicity and graphically implies the lesion as seen on x-ray. It is felt that the term will continue to enjoy popular usage.

As mentioned above, the interest in the harmless looking coin lesion lies in the fact that there is about a 37% chance that it represents malignancy. The chance of its being a primary bronchial carcinoma is about 30%.[1] Table 1 shows the distribution of malignancies in the combined series of Davis, *et al.*, which represents a total of 1,203 coin lesions. Bronchogenic carcinoma and bronchial adenoma, when grouped together, make up about 30% of the total. The most common pathologic entity in any series is the granuloma, representing 41.6% in this combined series. The most frequent benign tumor in this series was hamartoma, 100 in number.

TABLE 1—1,203 COIN LESIONS[1]

Bronchogenic Carcinoma	316	
Bronchial Adenoma	42	(29.7%)
Primary Sarcoma	10	
Lymphoma	5	
Metastatic Tumor	69	
	442	(36.7%)
Granuloma	502	(41.6%)
Hamartoma	100	

It should be pointed out that in the individual series which are grouped together in this combined analysis, the incidence of malignancy varies from about 7% to 55%. The reason for this wide variation is that none of the reported series can be properly compared to one another because of different criteria used in selecting the cases. Thus, size of the lesion, location, absence of calcification, or presence or absence of symptoms in the cases selected will obviously influence the number of malignancies in any given series. Nevertheless, in none of the series has the incidence of malignancy been insignificant.

In our series of coin lesions seen from 1950 to 1957, there are 24 cases. Despite the small number, the pathologic entities show

* Presented at meeting of the Wisconsin Surgical Society on September 20, 1957, Madison, Wisconsin.

Fig. 2A—Primary carcinoma, left lower lobe.

Fig. 3A—Metastatic carcinoma, left upper lobe.

Fig. 4A—Squamous cell carcinoma, left lower lobe.

Fig. 2B—Surgical specimen.

Fig. 3B—Resected specimen.

Fig. 4B—Resected specimen.

a fairly characteristic distribution. Table 2 shows the complete tabulation. Three of the twenty-four (12.5%) were carcinomas; two were primary and one metastatic.

TABLE 2—COIN LESIONS—1950 TO 1957

Malignant	3	(12.5%)
Granuloma	18	(75%)
Miscellaneous	3	(12.5%)
Infarct (?)	1	
Neurofibroma	1	
Pleural Fibroma	1	
	24	

One primary carcinoma (fig. 2) presented as an asymptomatic lesion in the left lower lobe in a 52-year-old man convalescing in the hospital from a coronary occlusion. Six weeks after the acute episode, bronchoscopy was done and proved negative. At thoracotomy, hilar node involvement was found; frozen section of one of these nodes revealed anaplastic carcinoma. Pneumonectomy was carried out, and mediastinal node dissection showed extension into the subcarinal nodes.

Figure 3 shows a metastatic lesion which was found in a 53-year-old woman who had undergone radical mastectomy 10 years earlier. The lesion was single and asymptomatic. Bronchoscopy was negative. At thoracotomy a left upper lobectomy was done, establishing the diagnosis of metastatic breast carcinoma. No other evidence of malignant disease has been found in this patient.

The third carcinoma (fig. 4) is somewhat large, measuring just over 6 cm. Despite its size, however, the lesion was asymptomatic and certainly would be included in the differential diagnosis of a coin lesion. The lesion was a squamous cell carcinoma.

Fig. 5A—Pleural fibroma, left lower lobe.

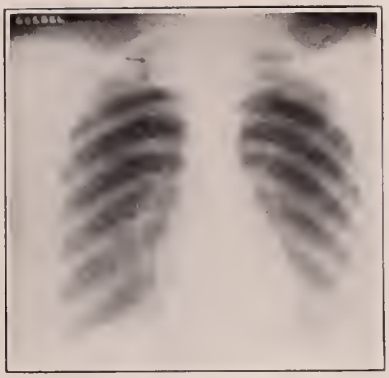

Fig. 6A—Neurofibroma.

Fig. 7A—Cavitary lesion.

Fig. 5B—Resected specimen.

Fig. 6B—Surgical specimen.

Fig. 7B—Surgical specimen.

Of the benign lesions, figure 5 is representative, and shows the manner in which a pleural mass may appear to be intrapulmonary. The tissue diagnosis was pleural fibroma.

Figure 6 shows a neurofibroma which, while adjacent to the mediastinum, is shown on the lateral view to lie anterior to the hilum.

The etiology of the lesion shown in figure 7 is not definitely established. It occurred in a 51-year-old man who was asymptomatic. Its cavitary nature is apparent. Microscopically there was no sign of granulomatous inflammation, and a partially re-canalized thrombus in an adjacent vessel suggested an infarct.

The group of 18 granulomas was evenly divided between the sexes, there being 9 men and 9 women. The patients' ages ranged from 18 to 70 years, with an average of 42 years. Fifteen of the eighteen were entirely asymptomatic, the lesion being first noted on routine chest x-ray. The three classified as having symptoms had had repeated upper respiratory infections with persistent cough, and in each case this had led to securing a chest x-ray. The relation of the coin lesion to these symptoms is open to some doubt.[2] In this connection it might be noted that several patients complained of fleeting and vague chest pain after being notified of the abnormal x-ray, but again these symptoms probably were unrelated to the actual pathology.

The distribution of the granulomas in the lung is shown in figure 8. In the larger reported series,[1] the distribution is much more equal between the various lobes, so that the coin lesion does not have a characteristic location. This is also true of tuberculous granulomas, a somewhat surprising fact in view of the predilection for tuberculous lesions to occur in the apical and posterior segments of the upper lobes and the superior segment of the lower lobes.

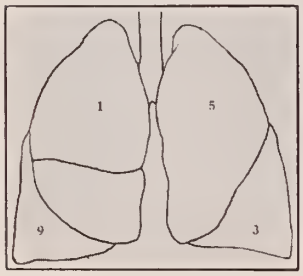

Fig. 8—Lobar distribution of 18 granulomas.

There was no postoperative mortality in this series of 24 patients. The most frequent type of procedure carried out was a wedge-resection, this technique being reserved for the granulomatous lesions. Lobectomy was performed four times, pneumonectomy once. Segmental resection was done five times. There were four complications, these occurring in two patients. The first complication was a Staphylococcus aureus wound infection. Three complications occurred in a 70-year-old female undergoing wedge-resection of the right lower lobe. She developed cardiac arrest during induction of anesthesia; emergency left thoracotomy was performed but a normal rhythm established itself before cardiac massage could be carried out. On the third postoperative day auricular fibrillation appeared and on the thirteenth day a deep venous thrombosis of the left leg appeared.

Fig. 9A—Smallest granuloma in series.

Fig. 10A—Largest granuloma in series.

Fig. 11A—Tuberculous granuloma, lingula.

Fig. 9B—Gross specimen.

Fig. 10B—Gross specimen.

Fig. 11B—Typical laminated cut surface.

A few of the representative granulomas are shown in figures 9 through 12. The smallest granuloma in the series (1 cm.) is shown in figure 9. It was in the posterior segment of the right upper lobe, and was due to histoplasmosis. The largest granuloma (3 cm.) was also caused by histoplasmosis, and is seen in the right lower lobe (fig. 10). A tuberculous granuloma (fig. 11) resected from the lingula, shows the typical laminated appearance on its cut surface. In contrast is a tuberculous lesion in the apicoposterior segment of the left upper lobe (fig. 12) which has a caseous, soft center.

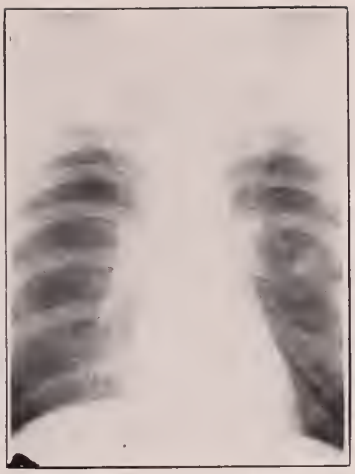

Fig. 12A—Tuberculous granuloma, left upper lobe.

Fig. 12B—Demonstrates caseous center.

The specific etiology of these granulomatous lesions is frequently difficult to determine, yet etiology is important from the standpoint of postoperative therapy. Classically these granulomas have been called "tuberculomas," but further work has shown that many such lesions are produced by fungi, principally Histoplasma and Coccidioides. Direct cultures taken from the resected lesions for acid-fast bacilli and fungi are sterile in the great majority. Special tissue stains for fungi have played a great part in separating the mycotic lesions from those due to tuberculosis, yet in most series there will remain an indeterminant group.[1]

In our series each granuloma was routinely stained with hematoxylin and eosin, and an acid-fast stain, and in none were organisms found. In addition, those resected within the past year and a half (eight) have been stained with the Gridley and periodic-acid Schiff stains and fungi have not been demonstrated. Six of the group were cultured for acid-fast bacilli and fungi and found to be sterile. Because of this we have arbitrarily separated the granulomas on the basis of specific skin tests. Thus 10 are considered due to histoplasmosis and 8 tuberculosis. The fallacy in basing the diagnosis on skin test reaction is that both the tuberculin and histoplasmin tests may be positive. In this series, such a situation arose only twice, and in each case the diagnosis of histoplasmosis was made because of a strong reaction to histoplasmin and a faintly positive reaction to tuberculin.

Postoperatively we feel that those cases diagnosed as tuberculosis should receive anti-tuberculous drug therapy and probably sanitarium care. The possibility of tuberculous spread following limited wedge-resection, without the benefit of preoperative antibiotic coverage, is ever present. We feel this complication is largely preventable if therapy is given. Six of the eight patients with tuberculous coin lesions were placed in sanitaria for periods varying from six to twelve months. The remaining two received anti-tuberculous drug therapy as outpatients.

Whereas it was formerly held that the demonstration of calcification indicated a benign lesion, there have now been enough reports of calcification in primary malignant lesions to give some pause. Generally calcification in malignant coin lesions is minimal, and takes the form of eccentric flecks; but centrally calcified cancers and lesions with peripheral rings of calcium have been reported.[1]

We tend to agree with those who recommend resection of all coin lesions, but we have made certain specific exceptions. The presence of multiple, well-calcified lesions on x-ray constitutes satisfactory evidence of benignity. Lesions which are solidly calcified throughout seem to merit observation. Finally, where previous films are available which show a partially calcified lesion which has been stabile over a period of at least one year, observation seems justified. This time interval is quite arbitrary, since Storey[3] reports a case in which a partially calcified

coin lesion remained stabile for six years, then began to enlarge. Thoracotomy revealed primary adenocarcinoma.

It becomes apparent in dealing with coin lesions that an extensive diagnostic workup is very frequently unrewarding in establishing a diagnosis. Bernatz and Clagett[4] report that thoracotomy was necessary to establish the diagnosis in 50% of a series of 356 coin lesions. We feel that the best diagnostic tool is exploratory thoracotomy. The surgeon, and not time, should establish the diagnosis.

(O.V.H.) 16 East Gorham Street.

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3. Storey, C. F., Grant, R. A., and Rothman, B. F.: Coin lesions of lung, Surg. Gynec. & Obst. 97:95–104 (July) 1953.
4. Bernatz, P. E., and Clagett, O. T.: Exploratory thoracotomy in diagnosis and management of certain pulmonary lesions, J.A.M.A. 152:379–381 (May 30) 1953.

DOCTOR ROGERS LECTURES SET FOR NOVEMBER 6–7

The seventh annual Dr. Malcolm F. Rogers lectures sponsored by the Wisconsin Heart Association in cooperation with Marquette University and the University of Wisconsin medical schools are scheduled for November 6 and 7 in Madison and Milwaukee. Dr. Gordon K. Moe, professor of physiology and chairman of the department at State University of New York, Syracuse, N.Y., will be guest lecturer. Doctor Moe's topic will be, "The Physiologic Basis of Cardiac Arrhythmias."

In Madison, November 6, a clinic is scheduled for 4:00 p.m. for physicians and students. The lecture will be given in the evening at 8:00 p.m. Both afternoon and evening meetings will be held in the University of Wisconsin Medical School.

In Milwaukee, November 7, a clinic will be held at County General Hospital at 3:30 p.m. Doctor Moe will give his lecture in the Marquette University School of Medicine auditorium at 8:00 p.m.

The Malcolm Rogers lectures are arranged each year with eminent physicians as guest speakers by the Wisconsin Heart Association as part of its medical education program. Doctor Moe's lecture will be the first in a series on cardiac arrhythmias and will be used to lay the groundwork for subsequent lectures on the subject. Future plans call for the publication of these lectures. The second lecture of the series will be given by Dr. Samuel Bellet, associate chief of cardiology, Philadelphia General hospital in Philadelphia, on February 25 and 26.

The lectures are open to both medical students, residents and physicians.

THREE MORE RADIO STATIONS NOW CARRYING "MARCH OF MEDICINE" PROGRAM

Since July, three more radio stations in Wisconsin have begun broadcasting the "March of Medicine" program. This brings the total number of stations carrying the program to 53.

The new stations are: WSHE, Sheboygan Falls, which carries the broadcast on Fridays at 2:45 P.M.; WRIG, Wausau, Sundays at 11:00 A.M.; WWIS, Black River Falls, Saturdays at 9:10 A.M.

The programs, which are tape recorded, feature Dr. R. C. Parkin, discussing various health problems with a lay person who is called "Your Medical Reporter."

Chemotherapy in Solid Tumors*

By A. R. CURRERI, M. D., and FRED J. ANSFIELD, M. D.

Madison

DESPITE the great technological and biological advances made in surgery, and the more powerful forms of x-ray irradiation and the wider use of radioisotopes, the control of neoplastic diseases must still be considered inadequate, particularly since two thirds of those afflicted die from this scourge. Undoubtedly, a higher salvage rate of approximately 50% would be possible if known techniques and knowledge were properly applied to allow earlier diagnosis and more definitive therapy.

For the eventual control of established tumors, it has appeared quite logical to look upon chemotherapy, either alone or in combination with surgery or radiation therapy, as having the greatest potential as a therapeutic modality. The first inkling of a breakthrough in this field occurred in 1946 when Goodman[1] reported temporary favorable response in a number of patients receiving nitrogen mustard for Hodgkin's disease, lymphosarcoma, and chronic leukemia. Interest mounted further when Farber[2] in 1948 dramatically demonstrated remissions in acute leukemia of children with a folic acid antagonist—4-aminopteroylglutamic acid. In the 10 years elapsing since these two reports, the accelerated activity in the laboratories and clinics has resulted in such a tremendous store of information that it appears apropos at this time to review the present clinical status of this problem. Since surgeons have been primarily concerned with solid tumors, this discussion will only touch upon leukemias and lymphomas which have been considered the province of the internists.

Antineoplastic compounds have been classified in numerous ways. Probably the simplest one is to consider two major divisions:

(1) Biological or natural agents—mode of action and/or chemical composition unknown, and

(2) Chemical compounds synthesized for specific purposes.

These two categories are not fixed ones for often the active portion of a biological product is isolated and later synthesized—to wit some of the antibiotics and vitamins.

BIOLOGICAL AGENTS

The biological chemotherapeutic agents can be further subdivided into five groups: (1) plant extracts, (2) bacterial products, (3) viruses, (4) hormones, and (5) antibiotics. Certain plant extracts, such as podophyllin, destroy external tumors but unfortunately all of them have been lethal when given parenterally in doses producing tumor necrosis.

Bacterial Products

Following the turn of the century, bacterical products received serious attention as anticancer agents. A number of reports related the tumorostatic effect which occurred with or immediately following serious streptococcal infections. On the basis of these observations Coley[3] produced a streptococcal vaccine, which now bears his name, and presumably was effective against sarcomas. In recent years Seligman,[4] at the National Cancer Institute, isolated the active principle, a polysaccharide, in the bacterial exudate. This polysaccharide was so potent that a microgram injected into a mouse with a transplanted tumor caused marked hemorrhagic degeneration within the neoplasm, the so-called Schwartzmann's phenomenon. In a few clinical trials the toxicity of this agent was too severe to warrant further human use.

Viruses

Viruses have again come to the fore as possible therapeutic agents. Presently, attention has been pinpointed towards the immunological aspects of the problem with the greatest emphasis towards developing a vaccine. Several years ago considerable interest was engendered by the neurotropic viruses which were shown to inhibit and cause tumor

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* From Cancer Research Section, Department of Surgery, University of Wisconsin Medical School.

Presented at the One Hundred Seventeenth Meeting of the State Medical Society of Wisconsin, Milwaukee, May 8, 1958.

regression. Unfortunately, these viruses also produced encephalitis.

Hormones

Hormonal therapy has influenced to a very considerable degree the course of metastatic carcinoma arising in the prostate and breast. The first step in controlling these hormone-dependent lesions was to deprive them of their endocrine stimulation through orchiectomy and oophorectomy, if the gonads were still active.

Testosterone, the most commonly employed androgen, found its greatest usefulness in the treatment of carcinoma of the breast. In these cases symptomatic improvement occurred in two thirds of these patients while objective regression was noted in only 25% to 30%. It was most gratifying to observe the dramatic response to testosterone therapy in patients bedridden by the intense pain caused by osteolytic bony metastases, because it resulted in ambulation, performance of housework, complete pain relief, and calcium deposition into the bony metastases. When therapy was effective in these cases, the urinary calcium balance studies manifested a sharp decrease in urinary calcium output. Somewhat less dramatic but nonetheless remarkable was the extent of tumor regression seen in soft tissues, lungs, liver, and brain.

The initial dosage schedule has been 100 mg. three times weekly. Patients on this regimen have developed masculinizing side effects consisting of hirsutism, deepening of the voice, acne, edema, and increased libido. These side effects, at a later date, have been reduced or minimized by decreasing the dose of testosterone to 100 to 150 mg. weekly or 200 mg. of depot testosterone biweekly. Unfortunately, palliation from androgen therapy has not been long sustained—from six months to three years.

Stilbestrol has been the estrogen of choice in the treatment of prostatic carcinoma and in postmenopausal breast carcinoma. With breast carcinoma in women who are at least five years past their menopause, dramatic, long-term tumor regression in approximately 30% can be anticipated. It has not been uncommon to maintain tumor regressions for two to five years when a favorable response to estrogens was obtained.[5] The mode of action of estrogens in controlling neoplastic tissue has been little understood. Stilbestrol has been given orally 5 mg. three times daily and the only significant or toxic side effects have been vaginal bleeding, edema, and increased blood calcium.

Disseminated prostatic cancer has responded more favorably to chemotherapy than any other malignancy. When combined with castration, stilbestrol in small doses of 1 to 10 mg. daily in divided doses has extended the life span and has reduced materially the morbidity of patients.[6] It has not been unusual for patients to enjoy freedom from pain, reduction or disappearance of metastatic tumor masses, and return to normal life activities for periods of three to ten years.

Eventually, both breast and prostatic malignancies have become resistant to hormonal treatment. This refractoriness has been explained in two ways. Huggins[7] postulated that after a period of time other endocrine glands, more specifically the adrenals or the pituitary, assumed the role of secreting the necessary steroids required for tumor growth. Hence, that is why many of these cases which become refractory to hormonal therapy responded to adrenalectomy and hypophysectomy. The second explanation supported the thesis that while most of the tumor was destroyed by the hormones, a few mutant cells remained inactive for a period of time and later developed the ability to survive independently of hormonal stimulation, became autonomous, and multiplied rapidly.

Cortisone has had a limited place in the chemotherapeutic armamentarium against solid tumors. This is in contrast to the use of this steroid in the critically ill child with acute leukemia where it produces temporary generalized clinical improvement. In a number of breast carcinomas where hormonal treatment failed, or the tumor became refractory, this steroid has produced a short term objective improvement of from two to six months. However, most patients have responded subjectively with a generalized sense of well being even though tumor regression is not evident. Cortisone has been given in doses ranging from 50 to 100 mg. daily in divided doses. When prednisolone was substituted, levels of 20 to 40 mg. daily in divided doses was considered adequate. *A word of caution is necessary with this high dosage of steroid since a number of patients may develop a generalized tissue edema.*

Considerable excitement was created recently by a number of reports demonstrating dramatic tumor regression in metastatic carcinoma of the thyroid after radical thyroid

and neck resection had been performed and thyroxin provided to the patient postoperatively. The rationalization behind this therapy lay in the fact that with thyroidectomy the secretion of thyroxin was markedly decreased. This sudden decrease in thyroxin stimulated the anterior pituitary to secrete thyrotropic hormone which in turn stimulated the growth of the metastatic carcinoma. The provision of large amounts of thyroxin inhibited the secretion of the thyrotropic hormones and the metastases regressed markedly and in some instances disappeared.

Antibiotics

The recent entrance of antibiotics into the chemotherapeutic picture has introduced a new series of compounds whose biological activity might in the future adversely affect neoplastic tissue. Three agents thus far have displayed anticancer activity in animal research and have been employed in a limited number of clinical studies. Thousands of brews still require screening studies and some of them may prove effective antineoplastic agents. Stylomycin[8] (Puromycin) in doses of 250 to 750 mg. daily showed little or no activity against human tumor tissue. Azaserine,[9] derived from Streptomyces, has been clinically used intravenously at 8 to 10 mg. levels daily to the point of toxicity, followed by a lower level. It produced some inhibition of lymphomas. No improvement was observed in the relatively small number of solid tumors studied. Actinomycin D[10] showed a degree of antitumor activity in laboratory animals and is presently undergoing clinical evaluation in the clinics. It is obvious that proper evaluation of the antibiotics as anticancer agents will come in the future.

CHEMICAL COMPOUNDS

Chemical compounds have been subdivided into two groups, namely:

(1) Cytotoxic Compounds—thought to act directly on the nucleic acids already formed, and

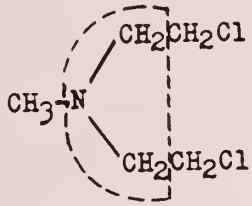
(2) Antimetabolites—inhibit or prevent formation of nucleic acid.

Cytotoxic

The cytotoxic compounds include the alkylating agents (nitrogen mustard), urethane, colchicine, and methylcholanthrene. Since the introduction of nitrogen mustard 12 years ago as an anticancer agent, a host of alkylating compounds have been synthesized and modified for this specific purpose. Many claims of superiority of one alkylating agent over another have been made by many investigators. It is the consensus of those having broad experience with these compounds that these nitrogen mustard-like drugs have similar and probably equal effect on most solid tumors, and any superiority of one alkylating agent over another may well be related to the greater experience of the investigator with a favored compound.

ALKYLATING AGENTS

The active portion of the nitrogen mustard molecule is the ethyleneimine. . . .

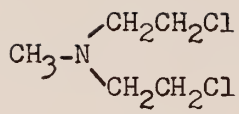


Nitrogen mustard is unstable in solution, losing 80% of its potency in 20 minutes. Because of its irritating and blistering effect on tissues, this compound has been administered intravenously and great caution taken to avoid leakage into the subcutaneous tissue or skin. When such an accident has occurred, the best antidote has been copious washing of the affected tissues. These compounds have often been termed radiomimetic agents because of their blistering effect and other body tissue changes which resembled those caused by irradiation.

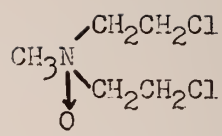
The total dose of a course of nitrogen mustard is 0.4 mg. per kg. of body weight given intravenously. It can be given in a single dose or divided into two or four daily doses. Most workers prefer to give nitrogen mustard .1 mg. per kg. of body weight on four successive days. Nausea and vomiting have been a frequent occurrence with the use of this compound, but these troublesome complications have been counteracted by chlorpromazine, 25 mg. three times a day, or prochlorperazine, .10 mg. three times a day.

When nitrogen mustard is oxidized, the resulting compound became known as nitromin (see fig. 1). This compound has been favored by the Japanese workers because its nonirritating characteristic permitted either intravenous or intramuscular administration and also a larger dose could be given over an extended period of time, making it pre-

ALKYLATING AGENTS



HN_2 - Nitrogen Mustard



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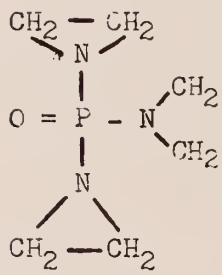
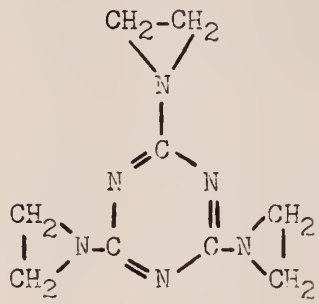
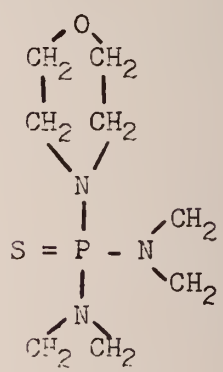


TEPA



TEM



OPSPA

Figure I

sumably effective against solid tumors. They have suggested a dose of 0.1 mg. per kg. of body weight every 10 to 14 days.

Triethylene melamine[11] (TEM) is a molecule containing three ethyleneamines attached to a melamine ring. It owed its popularity to the fact that it could be given orally and had an antitumor action similar to nitrogen mustard. Five milligrams of the compound is given three times in the course of one week. Nausea and vomiting, a frequent accompaniment of this agent, are combatted by some with sodium bicarbonate and with pyridoxine by others.

In the group of alkylating agents commonly called phosphoramides, the phosphorus replaces the melamine ring of triethylene melamine. The philosophy behind this modification is that phosphorus is required in rapidly growing cells and it was anticipated that the cell would avidly seek this element and thereby incorporate this toxic compound. The most popular and commonly used phosphoramide has been thiotepa whose dosage schedule is 5 to 10 mg. daily until signs of improvement or bone marrow depression occurs.

Oxapentamethylenediethylene thiophosphoramide[12] (OPSPA) was synthesized at the University of Wisconsin Medical School by Heidelberger and explored clinically by us. It was a modification of thiotepa with one of the ethylenemine groups replaced by oxapentamethylene ring. It was given parenterally 0.4 mg. per kg. of body weight every other day until signs of improvement or bone marrow depression appeared.

The most striking effects from alkylating agents have been in the lymphomas. A number of metastatic breast tumors, reticulum cell sarcomas, malignant melanoma, testicular seminomas, and lung tumors have responded for varying periods of time to these compounds. Recently Hatch[13] reported a higher yield of lung tumor regression when repeated courses of nitrogen mustard were given.

The injection of alkylating compounds into serous cavities has provided a simple and inexpensive method of controlling approximately 60% of pleural and peritoneal effusions due to metastases from carcinoma. This improvement has compared favorably with that of radioactive gold instilled into serous

cavities. In favorable cases there is marked or complete inhibition in fluid formation.

In instances of superior vena cava compression by metastatic masses in the mediastinum, the use of alkylating agents often has been life-saving. In contrast to radiation therapy which might initially increase the swelling of the metastatic nodes, this reaction has not been observed with alkylating agents. Since the vena cava decompression resulting from nitrogen mustard has been short-lived, it is followed by x-ray therapy for an additive effect.

Ethyl carbamate (Urethane)[14] has been found to have limited value in multiple myeloma. The toxic manifestations have included lethargy and diaphoresis in addition to the usual bone marrow depression and gastrointestinal upsets. It has been administered either orally after meals or intravenously in dilute solutions in doses of 2 gm. daily. Because of its limited action, attempts have been made to combine it with nitrogen mustard.

Demecolcin, a natural alkaloid related to colchicine, has the similar property of preventing mitoses and is less toxic.[15] Thus far no appreciable effectiveness against solid tumors has been noted.

A few months ago Huggins[16] proposed the use of methylcholanthrene which is a very potent carcinogen as a therapeutic compound, and reported tumor regression in a small number of solid tumors, particularly in nonhormonal-dependent breast tumors. Further clinical trial will be required for a proper evaluation of this agent.

Antimetabolites

The discovery of the need for folic acid to prevent anemia in chicks led Farber[2] to consider this metabolite in the treatment of acute leukemia in children. When this metabolite caused an acceleration of the condition in the bone marrow and viscera, Farber conjectured that an antimetabolite might inhibit cell growth. This conjecture proved correct and 4-aminopteroylglutamic acid the first strong antimetabolite employed produced complete, even though a temporary, remission of acute leukemia. Here because a fraudulent, useless building block was accepted by the cell, it was unable to build the nucleic acid necessary for its growth and survival.

In synthesizing the complex nucleic acid three substances are needed: (1) an enzyme, (2) a vitamin, usually one of the B group, or nicotinic acid, and (3) a substrate which consists of one of the basic materials or building blocks, *i. e.*, purines, polypeptides, amino acids, etc. This reaction can be represented as:

Enzyme + Vitamin + Substrate $\longrightarrow$ Nucleic Acid.

Thus when one or more of the fraudulent agents, the antimetabolites, are included into the reaction, nucleic acid synthesis is blocked.

The organic chemists and biochemists have been creating many antimetabolites whose chemical composition closely resembles or is analogous to those required in the synthesis of nucleic acid at its various levels of formation. Thus to:

(1) block folic acid—antagonists are 4-aminopteroylglutamic acid methotrexate.
(2) block amino acid—antagonist is DL ethionine.
(3) block purines—antagonists are 6-mercaptopurine, thioguanine.
(4) block pyrimidines—antagonists are 5-fluorouracil, 6 azouracil.

The most commonly used folic acid antagonist is methotrexate which is given orally in doses of 2.5 to 5 mg. daily to the point of remission or toxicity. It is most useful in acute leukemia of children and the remission occurring in these children is now well founded and has increased the average life span from 6 months to 3 years. The longest survivor is Farber's[2] patient who lived eight years after therapy was initiated.

The amazing report by Hertz[17] in which he described complete disappearance of metastatic masses and possible cure of malignant chorioepithelioma with methotrexate has now been corroborated by others. Recently an occasion arose in one of our patients which demonstrated the lytic activity of this compound on this lesion. A 20-year-old patient with extensive metastatic chorioepithelioma to the pelvis and peritoneum and a coin lesion in the lingula of the left lung had a hysterectomy and oophorectomy performed, followed by a course of methotrexate. All masses melted away, except for the coin lesion in the lung which continued to persist after two and one half months. At this time a segmental resection of the involved lung was performed and a microscopic study of

the lesion showed no evidence of viable tumor cells.

The only other frequent but temporary improvement observed has been the decrease in size of neuroblastomas, while other solid tumors have responded only on rare occasions.

The toxic effects caused by all of the antimetabolites have been somewhat similar. These compounds depress cellular regeneration in organs where this process is most active, *i. e.*, bone marrow and the gastrointestinal tract. In common they have produced stomatitis, diarrhea, bloody stools, bone marrow depression, and occasional hair loss. The toxicity of the antifolics has been counteracted by folinic acid. However, antidotes to the other antimetabolites have not been established.

The amino acid analogue DL ethionine has been both exceedingly toxic and too ineffective to warrant clinical use.

The most thoroughly investigated purine antimetabolite has been 6-mercaptopurine.[18] It has proved of value in the acute leukemia of adults but has shown little or no value in solid tumors. Thioguanine unfortunately was developed at the peak of popularity of 6-mercaptopurine and therefore did not have adequate clinical trial.

5-Fluorouracil, a pyrimidine analogue, was synthesized by Heidelberger,[19] Duschinsky, and their co-workers[20] specifically as a cancerostatic compound. When given at a dosage schedule of 15 mg. per kg. every 5 days and continued to toxicity, objective improvement with tumor regression was noted particularly in patients with breast cancers, large bowel tumors, hepatomas, reticulum cell sarcomas, and a number of others. The disadvantages of this agent have been that tumor regression has occurred only in those manifesting toxicity and its transient effect requires repeated courses of therapy at monthly intervals. This drug is very poorly tolerated by patients who have received large doses of x-ray irradiation to large flat bone areas such as in cervical carcinoma, by those previously receiving alkylating agents, and by the arteriosclerotic patient.[21]

DISCUSSION

Clinicians, particularly surgeons, have recognized the nearly insurmountable task assigned to chemotherapy in controlling or curing far advanced, metastatic carcinomata which have failed to respond to other modalities of treatment. A comparable analogy would have been to have anticipated a cure in an overwhelming septicemia from the use of prontosil or one of the earlier sulfonamides. Ideally, chemotherapy should be tried in early malignant lesions but at present one does not have the moral, ethical, or legal right to undertake such an unknown course when surgery and radiation therapy have been recognized as curative measures at this stage.

However, the stage can be set to evaluate the role of chemotherapy in the treatment of early malignant disease by administering it following surgical resection. Clinical experience has provided us with evidence that following so-called curative resection a certain percentage of patients develop metastases locally, regionally, and in distant areas. Moreover, in certain maligant lesions, such as those arising in the lung and stomach, the mortality rate within two years has been at least 80%. Experimental evidence also has shown how cancer cells can be implanted locally or cast into the blood stream by manipulation of the tumor at surgery, and that residual carcinoma can remain behind without the surgeon's knowledge. In these instances the use of chemotherapy at the time of surgery and in subsequent days might prevent metastases and recurrences, or control small residual lesions.

In order to ascertain the merit of this rationalization, approximately 20 universities and a number of veteran hospitals have agreed to undertake a cooperative study in which, by randomization of cases, a number of compounds will be tested against controls in patients subjected to resectional surgery for lung, stomach, breast, and coin lesions. The compounds will be given at the time of surgery and three days postoperatively. The combined effort will provide in approximately 18 months an adequate number of cases which will be statistically valid for an appraisal of the compound's value as an adjuvant to surgery in the control of these lesions.

It is apparent that a panacea or even a major breakthrough in the control of malignant lesions has not appeared on the horizon. Nevertheless, the problem is being aggressively attacked from many angles. For those afflicted with cancer the progress in chemotherapy has been steady and definite.

In addition, we have at our disposal a modus operandi for study, an accurate base line drawn from controls and recent compounds which can be used to compare the effectiveness of new drugs, and the means to prolong life and restore it temporarily to a useful one.

University Hospitals.

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INTERSTATE POSTGRADUATE MEDICAL ASSOCIATION ASSEMBLY, NOVEMBER 10–13

An up-to-date review of latest developments in surgery, medicine, obstetrics, and other phases of medical practice which are of direct concern to the practitioner will be provided in four days of concentrated teaching at the forty-third international scientific assembly of the Interstate Postgraduate Medical Association to be held November 10–13 at Cleveland, Ohio.

Three Wisconsin physicians will participate in the program. Dr. Edwin H. Ellison, of Marquette University School of Medicine, will be a member of the panel on "Diseases of the Biliary Tract and Pancreas" starting at 9:00 a.m. Tuesday, November 11. Dr. Harry Beckman, of Marquette University School of Medicine, will present a paper on "To Use or Not to Use the New Drug, That Is the Question!" at 11:30 a.m. on Thursday, November 13. And Dr. Robert F. Schilling, of the University of Wisconsin Medical School, will present a paper on "Drugs Most Effectively Used in the Treatment of Leukemia" at 3:00 p.m. on Thursday, November 13.

Foreign speakers include: Mr. C. Naunton Morgan, of London, England, who will present some subject on surgery at 9:00 p.m. on Tuesday, November 11; Dr. Hans Selye of the University of Montreal, who will speak on the subject of "The Physiopathology of Stress" at 2:00 p.m. on Wednesday, November 12; and Dr. E. Harry Botterell of the University of Toronto, Canada, who will have as his subject "Strokes as a Neurosurgeon Sees Them". This will be presented at 2:30 p.m. on Wednesday, November 12.

Wisconsin trustees of the Interstate Postgraduate Medical Association are: Dr. E. R. Schmidt, Madison, Dr. R. G. Arveson, Frederic, and Dr. William Hildebrand, Menasha.

ANNUAL ASSEMBLY OF OMAHA MID-WEST CLINICAL SOCIETY

Four full days of postgraduate study presented under the joint sponsorship of Creighton University School of Medicine and University of Nebraska College of Medicine will be held November 3, 4, 5, and 6 at the Sheraton–Fontenelle Hotel in Omaha, Nebraska. The assembly has been officially approved for Category I by the Commission on Education of the American Academy of General Practice. Attendance at each session of the meeting will entitle members of the American Academy of General Practice thirty-four hours of formal credit.

Panel discussions include: "Staphylococcus Infections," "Obstetric Shock," and "Common Fractures." A symposium on Thursday, November 6 starting at 2:30 p.m. will feature, "This is What's New!" Representatives from their respective fields will discuss briefly the most recent advances in medicine and surgery.

For further information write: John H. Brush, M.D., Director of Clinics, 1031 Medical Arts Building, Omaha, Nebraska.

TWO UNIVERSITIES TO PRESENT COURSE IN RECONSTRUCTIVE NASAL SURGERY

The department of otolaryngology of the College of Medical Evangelists and the department of otolaryngology of the University of Southern California School of Medicine, Los Angeles, jointly will present an intensive postgraduate course in "Reconstructive Surgery of the Nasal Septum and External Nasal Pyramid" at White Memorial Hospital, Los Angeles, in January 1959.

The course will be under the guest direction of Dr. Maurice H. Cottle, professor of the department of otolaryngology, Chicago Medical School, and with the cooperation of the American Rhinologic Society. Sessions will start Tuesday evening, January 6, and continue through Friday afternoon, January 9. They will be resumed Monday, January 12, and end at noon on Friday, January 16.

There will be lectures, surgical demonstrations, anatomical exercises, seminars, and case presentations. Special emphasis will be placed on the newer concepts of nasal anatomy, embryology, and physiology.

For further information, write Dr. Leland House, 435 South Soto Street, Los Angeles 53, California.

CHICAGO DIABETES ASSOCIATION SYMPOSIUM NOVEMBER 17

The Chicago Diabetes Association will conduct its second annual Symposium on Diabetes Mellitus at the Drake Hotel, Chicago, on Monday, November 17, 1958.

Physicians registering for the course will be charged an enrollment fee of $25.00, with the exception of members of the Chicago Diabetes Association, the American Diabetes Association, medical students, interns and residents, who may enroll without charge.

Inquiries should be addressed to:

CHICAGO DIABETES ASSOCIATION
5 South Wabash Avenue
Chicago 3, Illinois

INTERNATIONAL COLLEGE OF SURGEONS SET 1959 MEETING

The International College of Surgeons, 24th annual Congress of United States and Canadian Sections, will meet at the Palmer House, Chicago, September 13–17, *1959*. Write Dr. Ross T. McIntire, Executive Secretary, International College of Surgeons, 1516 Lake Shore Drive, Chicago 10, Illinois.

The Recognition and Management of Diseases of the Aorta and Great Vessels*

By JOHN T. PHELAN, M. D., and WILLIAM P. YOUNG, M. D.
Madison

BEGINNING with the publication by Robert Gross of Boston in 1949[1] that he had successfully employed a human homologous aorta to bridge an aortic coarctation defect, the surgical indications for diseases of the aorta and its branches have greatly increased in scope and variety. Such operative procedures as thromboendarterectomy, arterial by-pass procedure, and the use of artery homografts and plastic fabrics for arterial replacement have gradually entered into the vascular surgeon's armamentarium for diseases of this vessel. It is the purpose of this paper to review our experiences with such measures for diseases of the aorta and its branches.

Classification

In general, arterial diseases may be classified into two large groups; namely, (1) aneurysm, which is weakening and dilitation of the arterial wall, and (2) occlusive disorders, in which extrinsic or intrinsic narrowing or obliteration of the artery lumen is produced. In each instance the life of the patient, his limb, or its functional integrity may be endangered.

Occlusive Arterial Disease

The most frequent cause of aneurysm and arterial occlusion is atherosclerosis. These conditions may be abnormal metabolic processes, or may be the result of the stress and strain of blood flow. Regardless of etiology, the end result in all instances is intimal and subintimal deposition of atheromatous material. This may (1) narrow the lumen of the artery and act as a nidus for thrombus formation, or (2) by destroying the media and elastic layer of the artery wall, lead to aneurysmal dilitation.

Atherosclerosis probably is a systemic disease, with predilection for certain parts of the aorta and its branches. From our observation, the major arteries that give rise to few branches, such as the distal abdominal aorta (Leriche's syndrome), common iliac, external iliac, and superficial femoral artery in the region of the adductor canal, are the ones most frequently involved. The popliteal artery with its many tributaries does not become involved until late.

Other conditions that may produce occlusion of the aorta or one of its major branches are: congenital coarctation of the aorta, arterial trauma, neoplastic invasion of an artery, thromboangiitis obliterans, arterial emboli, and cystic medial wall necrosis.

It has been our experience that the signs and symptoms of arterial embolism are variable. In most instances the extremity becomes pale, cold, numb, and pulseless. The onset of pain and its degree are of minor importance as diagnostic criteria for this condition.

The location of an embolus may be at any point in the arterial tree distal to its origin. In some instances the site of an embolus determines the viability of the limb. For example, the popliteal artery with its numerous collateral branches appears to be a more favorable site, in respect to limb survival, than the common femoral artery which has few, if any, such branches. Other factors, such as age of the patient and degree of systemic atherosclerotic vascular changes, also play a part in determining the prognosis of an involved extremity.

Although limb survival may follow conservative measures for a peripheral arterial embolus, arterial insufficiency will occur unless blood flow is re-established by surgical measures. We have explored the posterior tibial artery and even the dorsalis pedis, extracted the clot, and obtained a pulsatile artery as well as a useful limb. While the length of time between onset and surgery may affect the chances for successful outcome, we have seen gratifying results when some type of arterial surgery has been attempted as long as six months after an embolic event. (Fig. 1)

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* From the Department of Surgery, University Hospitals, University of Wisconsin Medical School, Madison, Wisconsin.

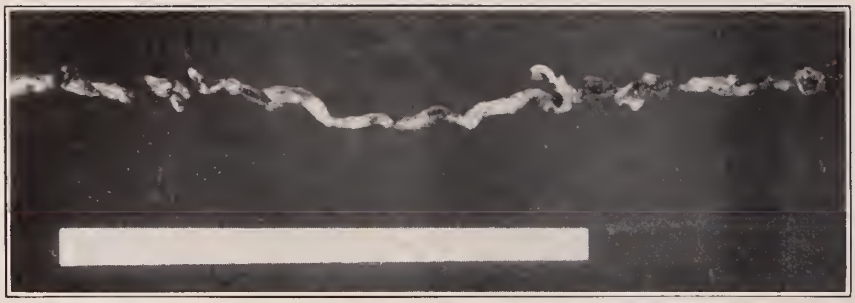

Fig. 1—Gross appearance of a thrombus removed via the superficial femoral artery of a patient with a history of an acute embolus. A normal functioning extremity resulted following this procedure.

Fig. 2—A femoral arteriogram showing occlusion of the superficial femoral artery at the adductor canal. In addition, this patient was diabetic with cellulitus of the foot and gangrene of the fourth toe, and presented absent peripheral pulse below the femoral artery. An arterial by-pass procedure was performed employing a femoral artery homograft. During the postoperative procedure, the cellulitis disappeared and the toe was subsequently amputated. A functionally useful limb was the end result.

Signs and Symptoms

The single, pathognomonic symptom of arterial insufficiency in a muscular organ, whether it be the heart or limb muscle, is pain or discomfort on exercise which disappears with rest. In the lower extremity this is known as intermittent claudication. As a general rule, calf pain suggests popliteal, superficial femoral artery, or common iliac artery occlusion, while thigh and buttock pain is usually associated with common iliac or hypogastric artery obstruction. In the majority of instances, the onset of symptoms is insidious, with gradual progression so as to shorten the distance the patient can walk. In those individuals who describe an abrupt onset, primary thrombosis or embolic occlusion of one of the major limb arteries must be suspected. Intermittent claudication is a symptom complex usually localized entirely to the lower extremities. Occlusion of the subclavian and/or brachial artery may, however, produce a similar condition in the arms.[2]

When pain at rest is predominant, arterial insufficiency is severe. In most instances, color changes, paresthesias, and coldness of the extremity are present. Such a condition does not necessarily preclude the possibility of successful surgical intervention. Even in the presence of impending gangrene, arteriographic studies and, if necessary, popliteal exploration should be done to determine the feasibility of reconstructive arterial surgery. In some gangrenous extremities, we have employed this technique, and not only have been able to limit the extent of the amputation, but also in some instances have preserved the limb. (Fig. 2)

Although occlusive arterial conditions of the lower extremities have received much of our surgical attention, an increased number of publications indicate that renal artery stenosis and carotid artery occlusion are amenable to surgical correction.[3] Hypertension of unknown etiology in children may be caused by constriction of the proximal aorta or renal artery. Adults with hypertension, or patients who have high diastolic pressures appearing after the age of 50, may have a renal artery stenosis. Carotid artery occlusion should be suspected in all patients with cerebral vascular accidents whose carotid or temporal pulses are absent. In addition, recurrent episodes of hemiparesis, hemiaphasia, and visual field defects, which may or may not completely subside, may very likely be associated with partial carotid artery occlusion.

Diagnosis

The diagnosis of occlusive arterial disease rests primarily on the history as well as on the ability of the physician to palpate the distal arteries. In each instance, all available pulse centers should be palpated. In the great bulk of cases, palpation localizes the level of obstruction; as an aid in detecting this level, the simple application of a blood pressure cuff to the thigh or calf, and observing the

fluctuation in the mercury level, has been found in our experience to be quite helpful. An obstruction of the internal carotid artery cannot usually be detected by palpation because of the high level of the occlusion; however, the common carotid artery is easily palpable over the medial border of the sternocleidomastoid muscle. Auscultation of the various superficial levels of the femoral and carotid arteries has been an extremely useful maneuver in determining when a partial stenosis exists. Under such conditions, a definite bruit is transmitted, as the hemodynamics that produce this phenomenon are similar to those producing certain abnormal heart sounds; namely, a change from laminar to turbulent flow.

Arteriography is useful in determining the level of an arterial obstruction. However, we consider it more as a means of determining the patency of the distal arterial tree. For without an adequate runoff distal to an occlusion, any type of surgical reconstruction is futile. At present, a lumbar aortogram is performed when the femoral pulses are absent. When the latter are palpable, and no evidence of aortic or iliac obstruction is manifest clinically, a femoral arteriogram is employed. If such procedure does not afford adequate visualization of the distal runoff arteries, such as the popliteal artery, we prefer to explore the artery in question and perform an arteriogram under direct vision. Lumbar aortography should not be taken lightly, since it may produce fatal renal tubular necrosis, inferior mesenteric artery occlusion, and transverse myelitis following the procedure. Whenever we perform lumbar aortography, we routinely hydrate the patient with intravenous fluids, and if possible, inject the radiopaque material below the renal arteries. At present, we are waiting at least ten days after an aortogram and reevaluating renal function before performing the indicated arterial surgery.

Treatment

All patients with occlusive arterial diseases should receive ancillary methods of investigation and treatment, including complete cardiac and renal evaluation as well as blood lipoid studies. If the latter are abnormal, dietary and drug measures are used. In addition, avoidance of tobacco, local heat and cold to the extremity, and proper foot hygiene are carefully explained to the patient.

3(a) 3(b)

Fig. 3—(a) Arteriography reveals right popliteal occlusion in a patient with severe, disabling intermittent claudication. (b) Patent popliteal artery following endarterectomy with complete relief of symptoms.

A number of techniques are available for the surgical reconstruction of an occluded artery. They are excision and grafting, arterial by-pass, and thromboendarterectomy. When the length of the occlusion is not over 5 cm. and is located above the inguinal ligament, we prefer a thromboendarterectomy. We employ an arterial by-pass procedure particularly in treating occluded segments of the superficial femoral artery. In some instances these by-pass procedures are of variable lengths. The longest one we have employed extended from the bifurcation of the aorta to the popliteal artery. In general, we are using more frequently some type of excision and grafting technique. Since our overall results with thromboendarterectomy have been so encouraging, we are of the opinion it deserves more consideration than it has received. (Fig. 3 and 4)

The selection of the proper type of artery graft is a complex problem. Most surgeons prefer plastic materials (dacron and nylon) to preserved artery homografts.[4] We have had success with both preserved artery homografts and plastic prosthesis; and at present we prefer artery homografts for the more peripheral artery reconstructive procedures, such as a femoral popliteal artery by-pass. For the replacement of the larger arteries and the aorta itself, we are using plastic prosthesis more frequently than ar-

4(a)

4(b)

Fig. 4—Preoperative aortogram of a 49-year-old patient who had progressive intermittent claudication and buttock pain, and was successfully treated by endarterectomy. (a) Shows complete occlusion of the distal aorta and common iliac arteries. (b) Gross appearance of material removed following endarterectomy. Follow-up study over a 2 year period has shown complete freedom of intermittent claudication with return to full employment. In addition there is no evidence of aneurysm formation.

tery homografts. Our experience with preserved artery homografts has been highly satisfactory and from a technical standpoint they are more easily managed than are their plastic counterpart.

During many of our vascular operative procedures, we routinely inject moderate amounts of heparin into the distal arterial tree. In addition, we employ postoperative heparin and/or bishydroxycoumarin-like agents in those cases whose distal runoff arteries are of a borderline diameter and when evidence of the atherosclerotic disease process is extensive. We also believe that maintenance of the systemic blood pressure is an important aspect of the postoperative care of these cases. In some instances, we have employed intravenous phenylephrine in dilute solutions so as to maintain the systolic blood pressure 10 to 15 points above the preoperative level.

Aneurysm

Pathology: Atherosclerosis has become the most frequent cause for aneurysmal formation. The aorta below the renal artery is the area most commonly involved. In addition, syphilitic aortitis involving the thoracic aorta, mycotic aneurysm, traumatic aneurysm, congenital aneurysm, and poststenotic aneurysmal formation distal to a coarctation are but some of the other conditions in which an aneurysm of the aorta and its branches may develop.

Clinical Manifestation: An aneurysm of the aorta, whether thoracic or abdominal, produces symptoms because of pressure on adjacent structures. It may remain asymptomatic for a long time, with the first symptom appearing at the time of rupture. In some instances, the rupture may be complete

and death ensue almost immediately. More often, however, the rupture is contained within the surrounding tissues. Under such circumstances the pain bears a distinct relationship to the size of the perforation: the large rent produces excruciating, tearing-like pain and shock-like symptoms, while the smaller perforation produces pain of less severity. Occasionally, a rupture may perforate adjacent viscera, such as the duodenum, esophagus, and tracheobronchial tree.

The most important sign of an aneurysm is a pulsatile mass. In some instances, a pendulous abdomen may make detection of the aneurysm difficult. A characteristic bruit often can be heard with the stethoscope. In addition, any pulsation below the umbilicus is highly suggestive of aortic enlargement. Care must be taken to distinguish between a tortuous aorta and an aortic dilitation. A horseshoe kidney or some other intraabdominal mass has in some cases been mistaken for an aortic aneurysm.

Diagnosis: In the majority of cases, the history and physical examination are all that are needed to confirm the presence of abdominal aneurysm. Not infrequently an x-ray of the abdomen, particularly a lateral view, will show calcification and dilation of a heretofore undiagnosed aneurysm. (Fig. 5) When such a condition is suspected in the thorax, a fluoroscopic examination is required. In some instances thoracic aortography is necessary. However, we seldom employ aortography to visualize an abdominal or peripheral aneurysm, as the diagnosis can be established by means already mentioned above. (Fig. 6)

A dissecting aneurysm is difficult to diagnose.[5] Chest pain, in the absence of laboratory evidence of myocardial infarction, plus absent peripheral pulse is highly suggestive of this condition. Aortography has been employed, and when it shows a discrepancy in the external and internal diameter of the aorta it establishes the diagnosis. Treatment for this condition[6] consists of excision and replacement with a suitable graft or a fenestration procedure.

Treatment: Previous methods of treating an aortic aneurysm, such as intraluminal wiring and wrapping with reactive material, have now been discarded. At present, excision of the aneurysm and establishing continuity by artery homograft or suitable prosthesis is the procedure of choice. In some peripheral aneurysms of traumatic origin, the endoaneurysmorrhaphy technique of Matas is very satisfactory. Simple excision may be employed; however, we believe that whenever possible arterial continuity should be established.

Fig. 5—Flat plate of abdomen, showing rim of calcification outlining the periphery of an abdominal aortic aneurysm. In most instances a lateral view of the abdomen is preferred.

When an abdominal aortic aneurysm appears proximal to the renal artery, a temporary by-pass during the period of occlusion during surgery has proved highly satisfactory in maintaining an adequate blood flow to such organs as the liver, kidney, and the gastrointestinal tract. In other instances, general hypothermia may be employed, as it prolongs the period of safe cross clamping of the aorta. An aneurysm involving the ascending aorta or the arch requires the use of a heart-lung machine, for in this manner oxygenated blood is returned to the cerebral arteries as well as to the branches of the distal aorta. These measures may sound extreme, but they are practical surgical techniques when employed properly for such disease conditions of the aorta and its branches.

Fig. 6—An aortogram showing an abdominal aortic aneurysm. At present, this procedure is not being employed as a diagnostic procedure for abdominal aortic aneurysm, as we are of the opinion that clinical sign and symptoms are sufficient to warrant an abdominal exploration.

Summary

We have reviewed some of our experiences at the University Hospitals with surgical conditions of the aorta and its major branches. In many instances, these diseased conditions are accompanied by degenerative changes elsewhere, as manifested by cardiac, renal, and cerebral abnormalities. Nevertheless, our overall results are encouraging, in that the salvage of a limb or excision of an aneurysm has added further comfort and usefulness to the lives of many of our patients.

1300 University Avenue.

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DR. ROBERT SHAW TO DELIVER DEARHOLT DAYS LECTURES

Robert R. Shaw, M.D., chief of thoracic surgery, Baylor University Hospital, Dallas, Texas, has been named speaker at the nineteenth annual Dearholt Days Lectures, November 10 and 11, according to an announcement from the Wisconsin Anti-Tuberculosis Association.

Doctor Shaw will speak on "Cancer of the Lung" in the William L. Coffey Auditorium at Milwaukee County General Hospital at 3:30 p.m., Monday, November 10, and in Madison, Tuesday, November 11.

He is a graduate of the University of Michigan School of Medicine and has been in his present position since 1949. He is a member of the American Trudeau Society.

The lecture series was inaugurated in 1937 to honor the late H. E. Dearholt, M.D., and to bring supplemental knowledge on tuberculosis and chest diseases to medical students and practitioners.

The 1958 Dearholt Days is the eighth in a series of events commemorating the fiftieth anniversary of the WATA.

Clinicopathologic Conference

Sponsored by the Section on Pathology, State Medical Society of Wisconsin
Guest Editor: Paul C. Dietz, M. D.

Report of a Case*

DOCTOR A. D. Aquino (Intern): A 63-year-old white, married truck driver was admitted to the hospital stating he had had mild continuous pain in the left infraclavicular region for two days. On the day before admission this pain had become a dull ache and had extended into the left lateral chest wall and was increased by inspiration. With it his appetite had waned, but there were no chills, cough, or hemoptysis; and in spite of it he had been able to work and sleep. No weight loss had occurred in the recent past. He had had influenza in 1917, right bronchopneumonia in 1936, and cholecystitis in 1948. Since then he had been well and had been working steadily. His family history included no instance of cancer, diabetes, or paralysis. He smoked one pack of cigarettes daily.

At admission his oral temperature was 101 F., his pulse rate 88, and the respiratory rate 22. He appeared well nourished although not obese. Abnormal findings at physical examination were limited to the chest. Impaired breath sounds and resonance and a friction rub were noted over the left lower thoracic wall. The heart was not abnormal. His blood pressure was 130/70. A large, circular shadow in the inferior portion of the upper lobe of the left lung, seen in x-rays, did not decrease in size with antibiotic therapy during the next three weeks of study. Intravenous pyelography revealed a normal excretory pattern. The red blood cell count was 4,300,000 and the hemoglobin 10.8 gm./100 ml. The white blood cell count was 11,000 with 67% neutrophils, 1% band forms, 26% lymphocytes, 2% monocytes, and 4% eosinophils. The urine had a specific gravity of 1.018 and contained 2 plus albumin, no urinary sugar and a normal sediment. The blood serologic test for syphilis was negative. A tuberculin skin test was read as 1 plus and a histoplasmin skin test was negative. The basal metabolic rate was plus 19. Vital capacity was 76% of predicted normal. Cold agglutinins were present in serum diluted 1 to 32. No pathogens were isolated on sputum or throat culture. Sputum specimens, bronchoscopy, and left scalene node excision yielded no evidence of tumor. The patient's temperature became normal 24 hours after admission and remained thus for three weeks. His chest pain also lessened and his appetite improved, although body weight dropped from 150 to 143 pounds during three weeks in the hospital.

On the twenty-second hospital day thoracotomy, lung biopsy, and frozen section revealed a well-differentiated bronchogenic squamous cell carcinoma, occupying the peripheral portion of the lower three-fourths of the left upper lobe. Left pneumonectomy was done. The tumor, measuring 12 cm. in diameter, was largely necrotic, had not metastasized to the included tracheobronchial and bronchopulmonary lymph nodes, had not developed satellite nodules, nor extended to the pleural surface and chest wall. It was apparently confined to the resected lung. Sterile visceral fibrinous pleuritis over the tumor was present. The patient tolerated the operation well; there was a temperature elevation to 100 F. for 48 hours and thereafter a normal temperature curve. A brief postoperative episode of paroxysmal atrial fibrillation was readily controlled with digitalis. He was discharged from the hospital on the tenth postoperative day with a hemoglobin level of 13.95 gm./100 ml., a white blood cell count of 8,900, a normal electrocardiogram, and an expected slight fluid accumulate in the left hemithorax and a normal right hemithorax as visualized in x-rays.

He remained at home for the ensuing six weeks where he was ambulatory, had a good appetite, and regained weight in a gratifying manner. He then returned to his former work on a limited basis. During the second week of work, fatigue and general bodily weakness as well as a moderately severe, steady ache in the legs, abdomen, and head

* From St. Francis Hospital, La Crosse.

developed. These symptoms were accompanied by anorexia, marked thirst, polyuria, and nocturnal hourly frequency of urination. Loss of strength increased for ten days, and on the day prior to his final admission this weakness became so pronounced that he was unable to walk without assistance. There had been no vomiting or diarrhea. He had been constipated for several days due to fecal impaction, but he required no laxative at any time.

He was readmitted to the hospital on the seventy-second postoperative day in a conscious state, although disoriented as to time and place and with loss of memory for recent events. These mental changes had developed on the preceding day. He weighed 137 pounds. His oral temperature was 98.6 F., the pulse rate 94, the respiratory rate 18, the blood pressure 140/88. The skin was clear and pale, the face not full, hair distribution normal. His pupils were round and equal in diameter and reacted slowly to light and accommodation. The thyroid was not palpably enlarged. The percussion note was impaired over the left aspect of the thoracic cage but was hyperresonant on the right. The cardiac point of maximum impulse was felt in the sixth intercostal space at the midclavicular line. Heart sounds were distinct. Paroxysmal atrial tachycardia was noted. There were no heart murmurs. Although the patient complained of generalized abdominal pain there were no abnormal abdominal physical findings, and no organs were palpable. The cranial nerves were intact. Tendon reflexes were hyperactive and equal. No Babinski, Kernig, Chvostek, or Trousseau sign could be elicited. There were no localizing neurological findings, paralysis, tremor, sensory disturbance, lymphadenopathy, cough, or dyspnea; but there was diminution of muscular power in all extremities. The patient now appeared acutely ill and exhausted.

The red blood cell count was 3,800,000, the hematocrit 36%, the hemoglobin 12.35 gm./100 ml., and the white blood cell count 8,700, with 61% neutrophils, 2% band forms, 33% lymphocytes, 4% monocytes. The corrected sedimentation rate was 30 mm./hr., and C-reactive protein was recorded as 6 plus. The urine had a pH of 7.0, a specific gravity of 1.011, and a slight trace of albumin. There were 2 white cells and occasional granular casts per high power field. The blood sugar was 110; the nonprotein nitrogen, 52; the creatinine, 1.4; the uric acid, 8.0; the serum calcium 9.5 mg./100 ml. Serum electrolytes in mEq/L were sodium 149, potassium 2.7, chlorides 89, carbon dioxide combining power 40. Plasma pH was 7.55. The cerebrospinal fluid was clear and colorless, contained one white blood cell per cmm., 79 mg. of protein per 100 ml., and was under 60 mm. of water pressure. The colloidal gold curve was read as 0000111100. Phenolsulfonphthalein excretion was 54% in 1 hour. X-rays revealed no bone destruction, tumor, or evidence of lesion within the thorax and spine, other than a markedly thickened pleura on the left, tracheal deviation to the left, and right compensatory total pulmonary emphysema. Left thoracentesis, done on the fifth hospital day, yielded 25 ml. of sterile, cloudy fluid, the sediment of which contained few neutrophils and no cancer cells.

After the patient had been in the hospital 48 hours his temperature slowly but steadily rose to an ultimate 104 F. His heart rhythm was that of paroxysmal atrial fibrillation. Restlessness, muscle spasm, and a positive Chvostek's sign were now noted. Fluid intake averaged 2,200 ml. and his urinary output 1,700 ml. daily. Treatment consisted of parenteral polyionic solution given in one liter quantity daily and containing 40 mEq potassium per liter, 38 mEq/L of oral elemental potassium as potassium gluconate, tetracycline, and a penicillin-dihydrostreptomycin combination, digitalis, and sedatives. On the day before death serum electrolytes in mEq/L were: sodium 164, potassium 3.0, chlorides 111, carbon dioxide-combining power 37; and the blood protein nitrogen was 54 mg./100 ml. Diaphoresis and coma developed on the fifth hospital day, and he expired on the sixth day, 11 weeks following pneumonectomy. At no time had he received diuretics, steroid hormones, or a sodium-restricted diet.

I have been authorized to divulge that a complete necropsy failed to reveal gross evidence of cancer.

Dr. D. M. Buchman: This man had a lung resected for bronchogenic carcinoma and seemed to be doing satisfactorily for seven weeks. Then, rather suddenly, he deteriorated. It is from this time on that his case acquires interest, and it is this portion of the clinical course which should be discussed. During the final stage of his illness signifi-

cant findings were: (1) muscle weakness which worsened rapidly; (2) widespread muscle pain and spasm without tenderness; (3) polydipsia, polyuria, and nocturia; (4) normal cerebrospinal fluid pressure, color, and sediment but an increased amount of cerebrospinal fluid protein associated with terminal hyperpyrexia; (5) certain mental changes proceeding to coma, undoubtedly with an organic basis although they do not help in localizing the lesion; (6) hyperreflexia and cardiac arrhythmia; (7) an alkaline urine with a specific gravity of 1.011, a slight trace of albumin, and occasional granular casts, associated with an elevated blood nonprotein nitrogen and uric acid but with a normal creatinine level; (8) an elevated sedimentation rate and C-reactive protein level, both of which, in the knowledge of a healing postoperative chest, are of questionable help to us; (9) an undoubtedly important electrolyte abnormality which may be summarized as refractory metabolic alkalosis with depression of serum potassium concentration. Somehow or other this array of findings will have to be dovetailed and ascribed to one or more lesions in one or more locations.

When the pathology department gives us a hint such as "no gross cancer found," I view that warily. The people who perform necropsies are not yet endowed with microscopic vision. I will assume that metastasis from the bronchogenic carcinoma must remain a possibility, and this in spite of the relatively favorable segmental location, histologic type, and apparent complete resectability of the primary tumor. Cancer of the lower respiratory tract has an insidious tendency to involve the regional lymph nodes, liver, bones, adrenals, kidneys, brain, heart, and pancreas. Apparently, there was no metastasis to bone, and one notes that the liver was not enlarged. Spread to the brain, adrenals, or kidneys has not been excluded. You will also recall that the resected tumor was found to be necrotic, and that metastatic foci from an inflammatory lesion primary in the lung can develop, especially in the brain. There is also the remote possibility that a generalized infection, undetected but perhaps activated by the operation, may have been present. Tuberculosis and mycotic infections come to mind. Finally, there is the possibility of a noninfectious disease involving one or more organs but not at all related to the original cancer. Whatever the lesion may have been, I favor one which replaces or destroys functional tissue. Metastatic tumor seems the logical choice.

As to the location of the lesion, an intracranial site must be considered as a possibility in view of the mental clouding and elevated cerebrospinal fluid protein. It should preferably be a small lesion since it did not produce an elevation of cerebrospinal fluid pressure, vomiting, and localizing neurologic signs. The diabetes insipidus-like clinical features make one think of a pituitary or hypothalamic location. Small lesions there are known to produce significant metabolic changes. Secondly, the bizarre serum electrolyte pattern, muscle weakness and pain, cardiac arrhythmia, and mental disturbance suggest adrenal hormonal disarrangement. It will also be of importance to decide whether this patient's disturbance of water and electrolyte metabolism may have been independent of the adrenal and pituitary. In that event one should consider the kidney as the possible site of disease. If metastatic tumor were present in the kidneys sufficient to have produced tubular dysfunction, such tumor would have had to be extensive and readily visible. Not only would that be unusual in the case of a metastasizing bronchogenic carcinoma, but we are told that no gross evidence of carcinoma was found at necropsy. Glomerulonephritis, pyelonephritis, and hydronephrosis are not likely diagnoses in view of the minimal albuminuria, normal pyelogram, few casts and the absence of erythrocytes in the sediment, the normal blood creatinine level, and the absence of edema and significant blood pressure rise. I do not know how we can properly exclude polyuria of pitressin-resistant nephrogenic diabetes insipidus, an entity similar to pituitary or hypothalamic diabetes insipidus but which is due to intrinsic deficiency of water retention by the convoluted tubules.

The peculiar electrolyte picture and the rapidly fatal course of this case suggest other conditions more strongly. One such disease, believed at least by some to be principally a renal disorder, namely potassium-losing nephritis, is not easily excluded. It is marked by a low serum potassium level, sodium retention, and metabolic alkalosis. Several years ago this diagnosis would have been a logical one for the electrolyte pattern seen in our case and the abrupt downhill course. Although there are undoubtedly rea-

sons for believing an entity such as an intrinsic renal tubular defect with potassium-losing characteristics can occur in the absence of other causes of potassium depletion, I would prefer another explanation for the total group of findings in this case. Somewhat reluctantly, because I would like to have additional renal functional data, I shall leave the kidneys from further consideration. However, whichever disease is finally decided upon will undoubtedly have had some effect upon the kidneys. Thus, we shall have to consider disease of two organs, the pituitary and the adrenals.

When talking about pituitary body lesions, we customarily refer to certain syndromes. For example, if this patient had diabetes insipidus due to a lesion destructive of the posterior lobe or the stalk of the pituitary, would that syndrome of polyuria, polydipsia, nocturia, and weakness include, or eventuate in, an electrolyte abnormality such as this man had? I think it would not. A pitressin test, a skull x-ray delineating the sella turcica, a glucose tolerance test, and additional urinalyses all would have been valuable aids in excluding diabetes insipidus. We do not have them. Could this, on the other hand, have been a lesion of the anterior lobe of the pituitary such as a basophil adenoma? In other words, did this patient have either hypophyseal cachexia or Cushing's syndrome? The cachexia, loss of axillary and pubic hair of Simmonds' disease are absent in our case. I believe we can probably exclude a postpneumonectomy, male analogue of Sheehan's post-partum pituitary necrosis, since there was no loss of hair, myxedema and sensitivity to cold, and because the serum potassium level was low rather than elevated. Did this patient then have Cushing's syndrome? A progesterone secreting ovarian tumor is, of course, excluded.

Three other hypotheses have been advanced to explain the moon facies, upper trunk obesity, weakness, muscle wasting, purple striae, tendency to mood lability and psychosis, tendency to easy bruising, osteoporosis, polyuria, polydipsia, latent diabetes mellitus, hypertension, variable hirsutism, and acne which characterize Cushing's syndrome. They are: (1) atrophy of the paraventricular hypothalamic nuclei due to denervation of the neural hypophysis; (2) adrenal cortical hyperplasia, adenoma, or carcinoma; and (3) since excessive circulating native adrenocorticotropin has not been found in Cushing's disease associated with adrenal hyperplasia, a corticotropin-potentiating secretion of pituitary or hypothalamic origin has been postulated.[1] The evidence given for the existence of the latter factor is purely circumstantial. Some cases of Cushing's syndrome do not have all of the classical components.[2,3] For example, osteoporosis, striae, overt diabetes mellitus, hirsuitism, acne, and hypertension may be absent. In fact, in rare cases one may see only extreme weakness and muscle wasting, or extremity-sparing obesity, or osteoporosis, or hypertension. This patient had no x-ray evidence of osteoporosis; and abdominal striae, moon facies, and abnormal fat distribution are not mentioned in the physical examination; hypertension was not present although the blood pressure had risen from 130/70 to 140/88 during the postoperative course; glycosuria was absent and a normal blood sugar level was obtained. I do not believe one can state that typical Cushing's disease was present although the case certainly has Cushingoid features. The courage to say this stems from the fact that approximately one-third of all cases of Cushing's syndrome have hypokalemic, hypochloremic alkalosis, which is of course, exactly the electrolyte pattern of our patient under discussion.

Therefore, if we were to postulate some pituitary or hypothalamic lesion, perhaps locally destructive of the neurohypophysis or at any rate capable of evoking a hormonal stimulus in turn able to effect adrenal hyperfunction, we could account for this patient's findings. This theory is insecurely grounded in the available clinical data. In any event, however, we can ascribe many of the Cushingoid findings to an overactive adrenal cortex. Another logical cause for hypopotassemia in this patient is not apparent. This man's low serum potassium level resisted attempts at repletion. Simultaneously he had evidence of sodium retention and elevation of serum pH and carbon dioxide-combining power. An abnormal adrenal is certainly capable of producing this pattern without aid from the kidney. Most authorities, including Doctor Conn of Ann Arbor, believe that the pathology one sees in potassium-losing nephritis is secondary to specific adrenal cortical hyperactivity. If, in this case, potassium-leaking renal tubules were the primary disease, why should such a rare condition

manifest itself just at this period in this patient's life? I think we should not consider our case to be one of potassium-losing nephritis.

Could the hypokalemic, hypernatremic alkalosis be a manifestation of atypical Cushing's disease due to metastatic bronchogenic carcinoma in the adrenals? A case of this type is described in the literature, and the author postulated that compensatory hyperactivity by the anterior pituitary had produced the electrolyte disorder.[4] The case reported by this author would undoubtedly have been called aldosteronism had our knowledge of the sodium-retaining corticoid aldosterone been as well developed at that time as it is now. Aldosterone is the hormone which was isolated by Simpson and Tait in 1952 from the "amorphous fraction" of adrenal cortex extract and is now accepted as the most important endocrine substance in the regulation of sodium and potassium metabolism. While it is a normal secretory product of the adrenal gland, its output may be increased due to intrinsic adrenal cortical disease, such as an adrenal cortical adenoma, hyperplasia of the cortex, or primary or metastatic carcinoma of the adrenal cortex.[5] Aldosterone excretion may also be secondarily increased in certain extrarenal disorders among which are nephrosis, congestive heart failure, cirrhosis, eclampsia, dietary restriction of sodium, intense sweating, and following surgical trauma.

The major clinical manifestations of aldosteronism are these: periodic severe muscular weakness, hypertension of variable degree, polyuria, polydipsia, hyposthenuria unresponsive to pitressin, alkaline urine, mild proteinuria, some degree of tetany with a normal serum calcium level, hypokalemia, hypernatremia, alkalosis, elevated urinary aldosterone acetate levels, normal urinary 17-hydroxycorticoids and 17-ketosteroids. Edema is usually absent in primary aldosteronism but is noted in certain types of secondary aldosteronism. Edema seems to have been absent in our case. The mechanism which increases the output of aldosterone by the adrenal cortex is not clearly established, although stimulation of the adrenal cortex by adrenocorticotropin is apparently not directly involved. When the adrenal is the site of malignancy, adrenal cortical steroids other than aldosterone may also be excessively produced and excreted. Certain features of classical Cushing's syndrome, such as moon facies, purple striae, and polycythemia, have been reported as being absent in primary aldosteronism. You will recall that these were not present in our case. Nitrogen retention has been noted in several of the sixteen-odd cases in the literature. It was found in our case.

I believe this patient was producing increased amounts of aldosterone, and I believe we can ascribe the principal findings to increased production and excretion of that hormone. I am not certain, however, that we can ascribe his death to this single cause. If he had metastatic bronchogenic carcinoma (and I believe he did) the combination of strategically situated adrenal or pituitary metastasis and the metabolic disorder can be held jointly responsible for the rapidly fatal outcome. I believe the muscular weakness and spasm, hyperreflexia, polyuria, polydipsia, hypokalemic hypernatremic alkalosis, mental disturbance, and urinary findings, are all compatible with aldosteronism. The abdominal pain one may ascribe to hypokalemic ileus. I am not aware of the expected spinal fluid findings in aldosteronism, but it is conceivable that in a severe case an increased cerebrospinal fluid protein might be found. Perhaps if additional recordings had been made available to us, more than moderate blood pressure elevation would have been uncovered; and, if the muscular weakness had been present longer and had been described in greater detail, it might have shown an element of periodicity. I am not certain of the pathogenesis of the aldosteronism in this case. It has been reported as a simple postsurgical complication, one not likely to have been the cause of death in so short a time period as seen here.[5] The improbable possibility that metastasis to the adrenal had an irritative effect upon the cortex, thereby increasing aldosterone output, has to be considered. Perhaps an unknown mineralocorticotropic stimulus related to some extra-adrenal metastatic cancer focus was operative. Whatever the cause of this stimulus and whatever its source, it continued to operate inexorably upon the adrenal cortex. Thereby, perhaps selectively, the adrenal cortex produced the hormone aldosterone in excess. Sodium retention followed and potassium was excessively excreted in turn.

I believe the patient had metastatic bronchogenic carcinomatous foci either in the re-

gion of the pituitary and hypothalamus or adrenals, or in both areas, which were the trigger mechanism behind adrenal cortical stimulation and excessive aldosterone production.

Dr. P. C. Dietz: Painstaking search revealed no evidence of metastatic tumor in any part of the body except the neurohypophysis. The heart was moderately enlarged, weighed 400 gm., and presented moderate coronary atherosclerosis and right ventricular wall lipidic degeneration, but no stigmata of hypopotassemic degeneration and necrosis. The emphysematous right lung was not involved by edema, tumor, and inflammatory reaction. The left hemithorax contained 100 ml. of cloudy nonpurulent fluid which was free of cancer cells as were also the thickened left parietal pleura and all thoracic, cervical, and abdominal lymph nodes. There was no excess of fluid in other serous cavities. Mild lipidic metamorphosis involved the liver, a finding not surprising in a patient with cancer. The combined renal weight was 450 gm. Sections of the kidneys revealed vacuolization of tubular epithelium, a change which was strikingly seen in the proximal convoluted tubules, was less marked in the distal convoluted portion, and which had spared the loops of Henle. These vacuoles varied in size and were occasionally accompanied by granular cytoplasmic disintegration. Differential staining revealed them to contain neither fat nor glycogen. The lower nephron, glomeruli, interstitial tissue, and vasculature were not remarkable. Evaluated in the light of the clinical aspects this is the nephropathy of potassium depletion, a well-documented pathologic entity. The adrenal glands weighed 24 gm. and were symmetrically enlarged with finely nodular cortical surfaces. Histologically, they presented nodular cortical hyperplasia with large polygonal sparsely vacuolated cells, confined to the inner two zones. Sudanophilic material and cholesterol-like substance of the cortex was reduced throughout, a pattern compatible with an actively secretory gland without appreciable storage. The hypophysis was enlarged, although the sella was not, and its posterior part was as large as the anterior and bulged upward. Within the anterior part there was hyperplasia of the basophil or "mucoid" cells arranged in cords and microscopic nodular masses, although this was not a true adenoma. Some of these cells contained areas of clear salmon-pink cytoplasm after the periodic-acid Schiff reaction while others appeared to be sparsely granulated. These changes are rather generally accepted to be pathognomonic of adrenal hyperactivity. In the midportion of the posterior lobe was a cystic, distinctly degenerative defect in communication with the stalk adjacent to which, and infiltrating the posterior-superior portion of the posterior lobe, were metastatic squamous epithelial cells like those composing the resected lung tumor. This was the only evidence of metastasis found. The third ventricle ependymal cells were compressed, indicating an increase of intraventricular pressure. Neurons in the paraventricular nuclei seemed to be involved by degeneration, perhaps as a pressure effect. These, then, were the principal findings at necropsy.

Secondarily induced hypophyseal-adrenal dysfunction had as much to do in causing the patient's death as did the locally infiltrative, destructive, and compressing midbrain tumor. One may say there was infundibular blockage of the posterior pituitary's supply of antidiuretic hormone from the paraventricular nuclei of the hypothalamus and that diabetes insipidus resulted in consequence. In 167 cases of diabetes insipidus encountered at the Mayo Clinic during the ten-year period from 1940 through 1949, there were 6 instances (4%) in which this syndrome was due to metastasis from carcinoma of the lung.[6] The authors of that report were able to find only 6 additional cases of diabetes insipidus due to intracranial metastasis from bronchogenic carcinoma in the literature.

To some this explanation will undoubtedly not account for all the terminal features noted clinically in our case, including the evidence of adrenal hyperfunction. For them perhaps the following supposition will suffice. The neural hypophysis, known in this patient to have been adversely affected by metastatic tumor, is normally in experimental animals in balanced antagonistic relationship with hormones secreted by the inner two zones of the adrenal cortex.[7] With lessened neurohypophyseal function is it not conceivable that hypersecretion of one or more adrenal cortical steroids would result? Just that has been observed to occur in dogs whose supraopticohypophyseal tract was surgically ablated.[7] Furthermore, it is now known that selective or permissive malsecretion of one or the other of the principal

adrenal cortical hormones can occur. Thus, aldosterone secretion, for example, could have been selectively increased and could, as Doctor Buchman reasoned, be held responsible for the peculiar electrolyte pattern, muscle weakness and spasm, and the urinary findings.

Unfortunately, such theoretical considerations were evolved too late for ante- and post mortem urinary aldosterone and 17-ketosteroid assays. Thus, we are forced to resort to speculation, something these conferences are, of course, intended to encourage. *In any event, it is safe to say the patient had a metabolic disorder of diabetes insipidus or aldosteronism type which was related to neurohypophyseal metastatic bronchogenic carcinoma.* Even though this may not have been a true instance of diabetes insipidus, it emphasizes the importance of metastatic intracranial tumors as a cause of diabetes insipidus-like symptoms and signs.

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MILWAUKEE ACADEMY OF MEDICINE SERIES DECEMBER 16–20

The Milwaukee Academy of Medicine will present to the medical public a series of conferences, clinics, and ward rounds to be directed by Dr. Arnold S. Relman concerning "Electrolyte Problems and Renal Disease" in particular, and also fluid and electrolyte problems as encountered in other fields of medicine. The series will start Tuesday, December 16, and continue through Saturday, December 20.

Dr. Relman is an Associate Professor of Medicine at Boston University School of Medicine, and physician in charge of the Renal and Metabolic Clinic at the Robert D. Evans Memorial Hospital.

All sessions are open to interested physicians without registration fee.

SCHEDULE

Evening Session:

Tuesday, December 16—University Club of Milwaukee, Social Hour and Dinner—6:00 P. M., Scientific Session—8:00 P. M.

Clinics and Rounds: 9:00 A. M. to 12:00 Noon

Wednesday, December 17—Milwaukee County General Hospital
Thursday, December 18—Veterans Administration Hospital, Wood, Wisconsin
Friday, December 19—Milwaukee Children's Hospital
Saturday, December 20—Milwaukee County General Hospital

"WORLD OF MEDICINE" TELEVISION SERIES NOW AVAILABLE FOR LOAN

The educational television series, "World of Medicine," which was originally shown on the entire 31 channels of the educational television network, is now available for loan to lay groups, civic organizations and service clubs from Schering Corporation, producers of the 13 one-half hour programs.

Originally the series was shown exclusively on educational television channels, however, because of its enthusiastic acceptance and recognition by interested medical societies Schering is making the program available for group showings on a no-cost basis.

Additional information on the series and dates for securing any one of the 13 programs may be obtained by writing to: Schering Corporation, "World of Medicine," Bloomfield, N. J.

Accidental Poisoning

As It Looks to Your State Board of Health

POTENTIALLY dangerous chemicals used in homes a generation ago could be counted on the fingers of one hand. Today, dozens of such substances can be found in every home. As physicians know, they include various types of cleaning powders and liquids, fertilizers, insecticides, beauty aids, and petroleum products as well as medicines like aspirin, barbiturates, and tranquilizers. These substances have such an important place in modern living that it is not surprising that accidental poisoning occurs so frequently.

While no actual record of the number of cases each year in Wisconsin is available, some idea of the size of the problem of accidental poisoning may be estimated from the Milwaukee experience in 1956. There the poison information center reported that 826 cases of poisoning were treated and 9 persons died during the one year. The number of cases treated at home were unknown. Estimates for the state thus approach 5,000 cases annually. In 1956, 44 deaths, and, in 1957, 32 deaths were reported as due to accidental poisoning.

The problem of poisoning may be considered both from the aspect of prevention and from that of treatment following ingestion of the noxious substance. The second is currently receiving a lot of attention over the state with the establishment of the Wisconsin Poison Information Center at the University Hospitals in Madison in April, 1958. This center provides information on poisons 24 hours a day, seven days a week. Through its services any private physician or emergency room personnel at a hospital may learn by phone the ingredients and antidotes of poison-containing preparations consumed by anyone, anywhere in the state. Information and treatment centers at hospitals have been in operation in Milwaukee for over two years and are also established in Kenosha and in Green Bay. Help in setting up such centers is available from the National Clearinghouse for Poison Control, an agency of the U. S. Public Health Service, through the State Board of Health.

The actual prevention of poisoning is a problem for everyone interested in safety and especially important for parents because the largest number of accidental poisoning cases occur in children under 5. This could be expected when we think of the natural growth patterns of children. They love to explore, climb, handle, and taste things but are without experience to judge what is safe or unsafe. The toddler still in the early exploratory phase carries everything to his mouth. When they stop to think about them, most people know these things but they may need special reminders. The family physician is a key person to extend such reminders.

For example, all adults and especially parents need to be reminded that drugs and household substances containing poisonous chemicals, whether labeled as such or not, should be kept out of reach of children, preferably under lock and key. Some emphasis on the natural curiosity and climbing ability of the growing youngster may help to determine safe places.

Some other rules for prevention will bear repeating: always store nonedible products in original containers and not in unlabeled bottles, familiar cups, or glasses; destroy medicines that have served their purpose, do not just throw them into a wastebasket or trash pile where children can find them easily; never give or take medicine in the dark. Parents need to be cautioned especially about giving medicine to children in more than the prescribed dosage or giving flavored or brightly colored medication and referring to it as candy. Sometimes "candy pills" become so attractive that children will search for more.

Even very small children can learn not to taste or eat unknown substances. This is a part of growing up and should be well understood long before they go to school.

When poisoning occurs immediate medical attention may be essential, preferably within the first 20 to 30 minutes after ingestion of a possibly poisonous substance. Then the services of the poison information center could be very important. With the increasing number of dangerous substances coming into our homes today these centers are likely to be called on more and more frequently.—CARL N. NEUPERT, M.D., *State Health Officer.*

Comments on Treatment

Editors—F. E. SHIDEMAN, M. D., University of Wisconsin, Madison
HARRY BECKMAN, M. D., Marquette University, Milwaukee

Medical Management of Acute, Chronic and Mixed Porphyria

Acute intermittent hepatic porphyria is a metabolic disorder characterized by the excretion of porphobilinogen and delta-amino levulinic acid in the urine. As the name implies, the excretion of these metabolites may be intermittent and need not parallel symptomatology. Therefore, repeated Watson–Schwartz tests for porphobilinogen[1,2] may be necessary to confirm the diagnosis and a physician must maintain a high rate of suspicion. Uroporphyrin may also be detected in the urine and the disorder is said to be inherited as a Mendelian dominant.

Symptomatology may include recurrent abdominal or back pains, usually without muscle guarding, and often accompanied by emesis with constipation, and occasionally diarrhea. Fecal impactions are frequent and there may be urinary incontinence or retention. Especially after administration of barbiturates or sulfonamide drugs, abdominal symptoms may give way to neuropsychiatric manifestations such as epileptic seizures, both generalized or focal; hysterical behavior; and psychosis of schizophrenic or depressive type. The level of consciousness may be reduced slightly or to levels of deep coma. Peripheral neuropathy is chiefly motor in type and accompanied during its inception by myoclonic jerks of the muscles. Bulbar paralysis may lead to a fatal outcome.

The diagnosis of acute hepatic porphyria is suggested by polysurgery, addiction, and by psychosis developing post-partum or postoperatively. Occasionally hemiplegia and paraplegia of central origin may be seen, as well as toxic amblyopia.

Chronic porphyria, or hepatic cutaneatarda porphyria, is manifested by the late onset of actinic or photosensitive cutaneous, often bulbous, lesions, whereas mixed porphyria incorporates both cutaneous and neuropsychiatric manifestations. In the chronic and mixed varieties, porphobilinogen need not appear in the urine in order to make the diagnosis which is based upon the presence of uroporphyrin and coproporphyrin. Increased metallic tanning or melanosis of the skin and hirsutism are seen in all three varieties. Even in the most severe cases, urine may be of normal coloration after exposure to sunlight; and the "Burgundy urine," or brownish urine described as typical in textbooks, is seldom mentioned by the patients.

Once the diagnosis has been made or suspected, barbiturates (especially the rapid acting variety), sulfonamides, alcohol, heavy metals, exposure to oil based paints, solvents, and sunbathing must be studiously avoided. Chlorpromazine hydrochloride,[3,4] in relatively high doses, or prochlorperazine are sometimes effective in controlling abdominal symptomatology, while use of meperidine hydrochloride may be necessary during the acute stages. The psychotic symptoms will, at times, respond to azacyclonol hydrochloride administration. Fatal cases have been described while under treatment with chlorpromazine hydrochloride. ACTH and cortisone have been utilized with many fatal cases recorded in the literature despite the employment of these steroids. When ACTH or cortisone are used, they must be employed in low dosage, since their persistent administration may soon give way to a fatal termination. Neurological and psychiatric symptoms when present are markedly aggravated by steroid compounds.

Chelating agents, which remove heavy metals from the body, have been recommended using dimercaptopropanol (BAL) or calicum disodium ethylenediaminetetraacetic acid (EDTA),[5,6,7,8] the latter being used preferentially when elevation of urinary lead complicates the picture. Elevation of urinary zinc in acute hepatic porphyria, as well as elevation of urinary copper excretion in the chronic, mixed, and occasionally acute varieties, has been noted with a zinc diuresis occurring during the use of chelating agents. Occasionally oral EDTA, in dosage of .5 gm. once to four times daily, has been used for maintenance regimens. BAL may be used in

dosage of 50 to 1,200 mg. per 24 hours in divided dosage and has been carried out for periods up to 60 days without toxic side effect, although sterile abscesses will occasionally develop. Intravenous EDTA may be employed in dosage of from 1 to 5 gm. in a 24-hour period diluted with 5% glucose and administered intravenously. When oliguria exists, cortisone, in low dosage and for short periods of time, may be helpful.

When severe peripheral neuropathy and bulbar signs are present, exceptional nursing care, tracheotomy, and careful attention to fluid and electrolyte balance must be given maximal emphasis. Total recovery from tetraparesis and bulbar paralysis has been recorded following chelation therapy with the recovery period extending from 6 months to more than a year. Treatment of chronic and mixed porphyria has also been carried out with chelating agents,[9,10,11] oral EDTA being effective in the chronic variety with disfiguring light-sensitive skin lesions.—HENRY A. PETERS, M.D.

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BAHAMAS CONFERENCES SCHEDULED FOR THE WINTER MONTHS

This coming winter there will be three Conferences at Nassau, Bahamas. The Sixth Bahamas Medical Conference will be held from November 28 until December 18. The First Bahamas Surgical Conference will be from December 29 until January 17, 1959. And the Serendipity Session, from January 18 until January 31, 1959.

The British Colonial Hotel will be the headquarters for all sessions. Reservations are being made now. American and Canadian citizens do not require passports. There are no tropical diseases in Nassau. The temperature will be around 70 degrees.

Further details may be obtained by writing to Dr. B. L. Frank, Organizing Physician, 23 East 79th Street, New York 21, N.Y.

HATS OFF TO ONEIDA COUNTY, NEW YORK, PHYSICIANS

The Medical Society of Oneida County, Utica, New York, in cooperation with the Utica Community Chest and Planning Council issued a *"Physician's Guide to Social Services for the Older Patient"* as the first step in its program to improve health care of the aged. The leaflet lists all the community resources available to older people in handy chart form. Categories include nursing and convalescent homes, family services, housing, home services, finances, employment, recreation, mental health, education, traveler's services, legal service and rehabilitation.

. . . . THE PRESIDENT'S PAGE . . . .

Mental Health

HEALTH projects—new developments in treatment—new surgical techniques—all of these, and many more, make headline news in our daily newspapers.

Not only do health projects make the headlines, but all too often do some voluntary organizations come into the picture, well meaning, but without proper medical direction.

In the field of mental health, it is of the utmost importance for such voluntary organizations to have adequate medical supervision. Many such agencies have established professional advisory committees of their own choosing, while others have liaison with the Division on Nervous and Mental Diseases of the Commission on State Departments of the State Medical Society of Wisconsin.

Sound medical principles must be reflected in all voluntary organizations having to do with the health—mental or physical—of the people of Wisconsin.

Too often in the past, has medicine given away its prerogative—direction of matters pertaining to health—to non-medical people.

Too often in the past, has the public been misinformed and uninformed, about the activities of organized medicine, aside from the daily practice of our profession, wherein dedicated men of medicine devote a lifetime of service, many times with poor material compensation, towards improving the health of the nation.

Our own State Board of Health, more than 20 years ago, began to direct activity in the field of prevention, as an effort to reduce the number of people added to an already large list of mentally ill cases. The State Board of Public Welfare, through the various institutions for mentally ill, under its jurisdiction, has seen to it that these unfortunate afflicted receive good care and treatment, designed towards returning the patient to a useful place in society. All of this, however, is done with adequate medical supervision.

Medical liaison, without exception, must be fully and properly utilized. Preventive mental health measures are to mental disease as vaccination is to communicable disease. Mental health programming in Wisconsin calls for recommendations in the near future as to how best develop an overall preventive program at local and state levels. Perhaps it would be wise to consolidate, into one agency, various state departments concerned with mental health. Perhaps certain aspects of state medical health programs should be better coordinated. However, the profession, legislators, the public, and various voluntary organizations who have interested themselves in mental health problems, should not forge ahead blindly and disrupt existing programs, which are well established and have been proved over the years as operating with excellent results.

To this end—the care of the mentally ill, preventive mental health measures, yes, all facets of the problem—I would suggest to my colleagues that we have the courage to change those things which can and should be changed and have the wisdom to accept those which cannot.

Jerome W. Forsth

Editorial Comment

Major Medical Not Doctors' Gold Mine

The trouble that major medical insurers are having in keeping doctors' fees in line, notably in southern California, is an oddity that has no exact precedent or analogy.

The problem arises out of the doctors' long-standing practice of grading their charges to fit the patient income level. This seems like a reasonable, and even a humanitarian way of handling things. But what happens when the patient whose means have been limited becomes in effect, rich as Croesus at least as far as his medical expenses are concerned, by having an insurer ready to back him for expenses that he would go broke trying to pay on his own?

The problem is quite similar to what has happened with automobile bodily injury and property damage insurance. The high and increasing level of automobile liability verdicts is obviously due in no small part to the fact that the money is there to pay—thanks to the insurers. And as high verdicts have scared people into buying higher limits, the juries have become more liberal still with what they still consider to be other people's money. Of course, it is not other people's money—as the increasing premium rates for automobile liability clearly show.

It would seem, at first glance, that the doctors have a plausible point when they regard a major medically insured patient as far more able to pay than he was before he bought the insurance. Doctors may well wonder why they should temper the wind to the shorn lamb who, as far as ability to pay for medical expenses is concerned, is very heavily endowed with fleece.

On the other hand, a good case could be made for the concept that the patient with major medical insurance is certainly no richer than he was before, and in fact is poorer by reason of the substantial premium he pays for major medical. So why doesn't the doctor give him a break, or at least charge him no more than before he bought the major medical? After all, a lot of the major medical is for the doctor's benefit. Many patients who have this coverage might just have to leave the doctor holding the bag if they were not so heavily insured.

What we actually have, of course, is a totally new kind of situation. It is a situation in which a relatively poor man may have, through insurance, an ability to pay his medical expenses that would jolt the general run of well-to-do patients. Clearly, new standards are needed. It will not do for the doctors to take the view that because it costs the patient no more to pay a huge medical bill than not to pay it, he is therefore to be charged just as if he were one of the rich people. If this sort of thing goes on very long it is obvious that the premium for major medical will be pushed so high that it will prove unsalable, the coverage will lose popularity, and the doctors will be as bad off as they were before.

Traditionally, doctors have jealously guarded their right to charge what they please. Nevertheless, in the interest of the benefits the entire medical profession will enjoy through the increased spread of major medical, it is incumbent on the relatively few physicians who see major medical as merely a personal gold mine to lay off.

Medical societies in some areas have done much to help this situation. Even in southern California, where the situation has been particularly troublesome, there are signs of progress, as was pointed out by J. Edward Day, vice-president in charge of Prudential's Los Angeles regional home office. The most hopeful development seems to be a relative scale of values not based on dollar amounts but setting up reasonable ratios between various types of treatments and operations.

After all, it may be difficult to convince a doctor that he should not charge 50% more for a given operation than the usual charge for that operation. But when he has to justify the "relativity" of such a charge to other charges he makes for other operations, his position becomes pretty weak. In brief, it makes cases of gouging show up for what they are.

We believe that the great majority of physicians and surgeons are more than willing to help make major medical and other forms of insurance work to the best advantage of patient and doctor. Unfortunately, a few short-sighted greedy doctors can do a lot to hamper the progress of insured plans. It is fully as much to the advantage of their conscientious colleagues to keep these fellows in line as it is to the benefit of the patients and insurers.—*R. B. M.*

(Reprinted from the August 15, 1958, issue of The National Underwriter)

HOUSE of DELEGATES

REPORT • APRIL 1958

THE STATE MEDICAL SOCIETY OF WISCONSIN

The House of Delegates is the legislative body of the State Medical Society. Delegates are charged with the responsibility of guiding and directing the policy and activities of the Society and the best interests of the people of Wisconsin and the medical profession.

The following pages are devoted to detailed reports of the activities of the Councils, Commissions, Divisions and the Committees of the Society, which were presented at the 117th annual meeting in Milwaukee May 5, 6 and 7, 1958.

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RESOLUTION NO. 1

Introduced by

Douglas County Medical Society

WHEREAS, The proponents of compulsory Old Age and Survivors Insurance for physicians are again soliciting support among their colleagues; and

WHEREAS, The advantages and disadvantages of Social Security for physicians have been adequately publicized in both lay and professional journals; and

WHEREAS, The individual members of the medical profession have had no opportunity to state their personal preference regarding compulsory Federal Old Age and Survivors Insurance coverage to physicians,

Now, therefore, be it resolved, By the Douglas County Medical Society, at its regular meeting on March 5, 1958, that its representative to the House of Delegates sponsor a resolution authorizing and effecting a referendum among all members of the Wisconsin State Medical Society, to be conducted by mail by secret ballot, on the following question: "Do you favor compulsory Federal Old Age and Survivors Insurance for the medical profession?", and

Be it further resolved, That the results of the referendum be tabulated for each county medical society and published in the Wisconsin Medical Journal.

RESOLUTION NO. 2

Introduced by

La Crosse County Medical Society

WHEREAS, The La Crosse County Medical Society met in regular business meeting on March 17, 1958, and

WHEREAS, Certain members of the said Society expressed a definite opinion favoring the encouragement of the State House of Delegates of the Wisconsin State Medical Society to forward a resolution to the House of Delegates of the AMA to reverse the present (contrary) stand on the question of Social Security coverage of the members of the medical profession, and

WHEREAS, Said members expressed a definite opinion favoring the House of Delegates of the Wisconsin Medical Society to instruct the state delegates to the AMA meeting in the coming convention to favor such an opinion in the House of Delegates at the coming meeting, and

WHEREAS, A motion to the above effect was made by Doctor McMahon of the La Crosse County Medical Society and duly seconded, and was passed by a vote of that Society,

Now, therefore, be it resolved, That the State House of Delegates of the Wisconsin State Medical Society introduce a resolution before the House of Delegates of the American Medical Association in the coming annual meeting to change the AMA policy concerning Social Security for the individual, private, self-employed practitioner to that of favoring such coverage, and that the state delegates to the AMA meeting be instructed by the House of Delegates of the Wisconsin State Medical Society to favor such a policy at the meeting of the AMA House of Delegates in the coming annual meeting.

RESOLUTION NO. 3

Introduced by

Rock County Medical Society

WHEREAS, The American Medical Association and the State Medical Society of Wisconsin have gone on record as opposing compulsory social security for self-employed physicians, and

WHEREAS, This subject has been adequately presented by proponents and opponents of social security before the Rock County Medical Society during the past year, and

WHEREAS, The physicians of Rock County have indicated by a poll of its membership that they are favorable to social security for physicians, and

WHEREAS, This subject will probably be considered at the annual meeting of the State Medical Society in May, 1958,

Now, therefore, be it resolved, By the Rock County Medical Society that it approves compulsory social security for physicians, and

Be it further resolved, That the delegates of Rock County have been instructed to vote affirmatively on the question of Compulsory Social Security for physicians at the 1958 meeting of the State Medical Society in Milwaukee.

RESOLUTION NO. 4

Introduced by

Marinette–Florence County Medical Society

WHEREAS, The Forand, Proxmire and similar bills in the current session of the congress provide for drastic expansion of the Social Security Act to provide benefits for hospital and surgical services to those eligible for retirement benefits, and

WHEREAS, Such a system could prove so costly as to jeopardize the retirement plans of millions of Americans who have placed their trust in Social Security for basic retirement needs, and

WHEREAS, The substantially increased taxes required to pay for this virtually unlimited program would raise federal OASI taxes to the point where they would almost duplicate income taxes, and

WHEREAS, This hastily conceived legislation has been introduced without careful study of the specific medical needs of older persons and apparently without knowledge of the abilities of voluntary health insurance programs to meet this problem in a reasonable period of time,

Now, therefore, be it resolved, That the Marinette-Florence County Medical Society opposes the Forand, Proxmire and similar bills in their provisions for hospital-surgical benefits under the conditions which have been outlined above and suggests that a thorough study of the entire Social Security Program, including needs of the aging, be made before a positive action is taken on any such measures.

RESOLUTION NO. 5

Introduced by

Dane County Medical Society

WHEREAS, The Council and its Commission on Medical Care Plans authorized the experimental development of a program of prepaid health care insurance which eliminated the conventional structure of schedule of benefits for surgical procedures, maximum benefits for medical care in the hospital and other maximums involving radiology and anesthesiology associated with surgical care, substituting in lieu of such schedules a maximum of liability and paying for services required by a patient regardless of classification and in the usual, reasonable and customary amount charged in the area where such services are rendered, and

WHEREAS, This program was first purchased in Racine County and the Racine County Medical Society provided full administrative and policy cooperation in its operation, and

WHEREAS, The success of the experiment depended almost in its entirety upon the cooperation of the Racine County Medical Society, and

WHEREAS, Such program is now being extended to other areas of Wisconsin due to its success in Racine County,

Now, therefore, be it resolved, That this House of Delegates formally record the appreciation of the State Medical Society of Wisconsin to the Racine County Medical Society for its pioneering efforts in this program.

RESOLUTION NO. 6

Introduced by

Third Councilor District Delegates

WHEREAS, The Council and the Commission on Medical Care Plans of the State Medical Society of Wisconsin have been directly responsible for negotiations with the Army, as agent for all armed forces, in which the Medicare program in Wisconsin has been developed, and

WHEREAS, In such negotiations the Army has sought to require Wisconsin to segment the surgical fee permitted as a maximum into asserted component parts of surgery only, postoperative care in the hospital, and postoperative care following hospitalization, and

WHEREAS, Wisconsin has negotiated a "control" schedule under which the customary and usual fee normally can be allowed, with special reports being made where circumstances may justify a higher fee, and

WHEREAS, This arrangement renders unnecessary the distribution of a pre-determined benefit in the manner sought by the Army, and such position has been taken by Wisconsin, and

WHEREAS, Arbitrary values on services rendered, without regard to extent, is abhorrent to the profession,

Now, therefore, be it resolved, That this House of Delegates commend the Council and the Commission on Medical Care Plans for their efforts in this and in other problems relating to the administration of Medicare.

RESOLUTION NO. 7

Introduced by

Wood County delegate and alternate delegate Doctors R. W. Mason and E. C. Glenn

WHEREAS, It is the publicly stated policy of the American Medical Association, by repeated actions of its House of Delegates, that hospital expense benefit programs should not include medical services since "insurance plans of this type will result in lowering the quality of medical care", and

WHEREAS, The State Medical Society of Wisconsin operates Blue Shield of Wisconsin as one of its activities, and

WHEREAS, The practice of radiology, anesthesiology, pathology and physiatry constitute the practice of medicine, and

WHEREAS, Benefits for such services should be included as Blue Shield benefits consistent with resolutions of the American Medical Association, and

WHEREAS, Blue Shield of Wisconsin has made notable strides in accomplishing this result,

Now, therefore, be it resolved, That this House of Delegates commends the direction of Blue Shield in this respect and urges the Council and its Commission on Medical Care Plans to fully implement this effort as soon as practical.

(See Resolution 34, 1953 AMA Clinical Session, Published in the Organization of the Journal of the American Medical Association, January 2, 1954, Vol. 154, p. 67.)

RESOLUTION NO. 8

Introduced by

D. M. Willson, M.D., Chairman Milwaukee Delegation

WHEREAS, The Milwaukee delegates to the State Medical Society have expressed much concern over the separation of Wisconsin Blue Cross and Wisconsin Physicians Service and;

WHEREAS, A special committee has been appointed and has studied all the available facts surrounding the separation of Wisconsin Blue Cross and Wisconsin Physicians Service and;

WHEREAS, This change involves patient care in Wisconsin and;

WHEREAS, There is also much concern of the decision to separate Wisconsin Physicians Service and Wisconsin Blue Cross inasmuch as the action occurred immediately following the adjournment of the House of Delegates and was never referred to the House and;

WHEREAS, Ostensibly the matter was considered by the Council only and the Council then delegated any action regarding this matter to the Commission on Medical Care Plans for action and;

WHEREAS, It is believed that this decision was too important for Commission action and an action which should have been brought before the House of Delegates according to the Constitution of the State Medical Society (Article V) and;

WHEREAS, At no time were the members of the State Medical Society of the State of Wisconsin notified that this important issue was being discussed;

Therefore be it resolved, That the House of Delegates of the State Medical Society be requested to appoint a five-man committee, to be composed of two Milwaukee delegates and three delegates from elsewhere in the State, and containing no present nor past officers nor councilors of the Society, to conduct a thorough study of

(a) The structure, function, and duties of the Council, including duties delegated
(b) The structure and duties of the House of Delegates
(c) The structure and duties of the staff of the State Medical Society and to whom they are responsible, both for routine and policy decisions
(d) The operation of Wisconsin Physicians Service as it affects the health picture, public relations between the public and the medical profession, and as it affects relationships within the medical profession;

It is further resolved, That consideration be given to studying the Constitution of the State Medical Society, which was adopted many years ago and may not now be the most workable for the Society in carrying on its present day activities and;

It is further resolved, That to assist and advise this committee, a suitable firm of management engineers, consultants, or specialists in medical association administration, organizational bodies, bylaws and procedures be retained and made available;

It is further resolved, That the sum of $10,000 be appropriated to initiate this study.

This resolution is the result of many meetings of the Delegates from Milwaukee County and has their unanimous approval.

Will you kindly see that this resolution is properly presented to the House of Delegates according to the Constitution and By-Laws?

RESOLUTION NO. 9

Introduced by

Third Councilor District Delegates

WHEREAS, The resolution introduced by the Milwaukee delegation petitioning the House of Delegates to provide a special committee for the purpose of studying the structure, function, and duties of the House of Delegates, the Council, and the staff of the State Medical Society, as well as certain other matters, such committee to have five members, two of whom shall be from Milwaukee, and three from the state, and

WHEREAS, Such resolution affects the interests and responsibility of each of Wisconsin's 53 component county societies, and

WHEREAS, By provision of the Constitution and Bylaws, the component societies are divided into councilor districts, each such district having at least one councilor, except in those districts where there is a membership of 250 or more "there shall be elected one additional councilor for each additional 250 members or major fraction thereof," and

WHEREAS, This is an established pattern of the Society's organization to permit geographic representation on important bodies;

Now, therefore, be it resolved, that: 1. Should the petition of the Milwaukee delegation be acted upon favorably, then such committee shall be organized by councilor districts, and its membership designated

in the same manner, that is, by representatives of the county medical societies within each such district, thus creating a committee of 18, five of whom would be from Milwaukee County; and

2. Such membership be announced as in the manner of councilor nominations at the third session of the House of Delegates.

RESOLUTION NO. 10

Introduced by

Third Councilor District Delegates

WHEREAS, The resolution of the Milwaukee delegation directs among other things a study of "the operation of Wisconsin Physicians Service as it affects the health picture, public relations between the public and the medical profession, and as it affects relationships within the medical profession," and

WHEREAS, The Milwaukee delegation expresses concern over the fact that Wisconsin Physicians Service, which is an activity of the State Medical Society of Wisconsin, is employing its own sales force rather than contracting for the employment of the Blue Cross sales facilities, and

WHEREAS, Wisconsin Physicians Service does not operate in Milwaukee which has been reserved for its associated plan, Blue Shield of Milwaukee, also known as Surgical Care, and

WHEREAS, The Milwaukee resolution is presented but three weeks prior to the 1958 sessions of the House of Delegates, and

WHEREAS, The other twelve councilor districts should have opportunity to engage in the same study, and

WHEREAS, The Milwaukee delegation states its resolution to be the result of "many" of its meetings, and

WHEREAS, The fact that the Milwaukee delegation was making such study was at no prior time made known to the members of the State Medical Society;

Now, therefore, be it resolved, that: 1. This resolution be referred for discussion in each councilor district of this state;

2. This resolution be referred to the Council and Officers, and the Commission on Medical Care Plans for their discussion and report, if they so wish; and

3. That the Council be requested to call a special meeting of this House of Delegates when reasonable time has elapsed for consideration of this subject, the resolution to be lifted from the table at such time.

RESOLUTION NO. 11

Introduced by

Third Councilor District Delegates

WHEREAS, The resolution of the Milwaukee delegation calls for the appointment of a special committee to make certain studies of affairs of the State Medical Society, and

WHEREAS, Such resolution specifies that "no present nor past officers nor councilors" of the Society shall be on such committee, and

WHEREAS, Such resolution embraces areas of service by Surgical Care of Milwaukee, a division of the Medical Society of Milwaukee County, which plan is not mentioned or included in the Milwaukee resolution.

Now, therefore, be it resolved, That as a further condition to eligibility to serve on any such committee, no matter how otherwise composed, no member shall be either a present or past officer of the Medical Society of Milwaukee County, a present or past member of the Surgical Care Operating Committee, nor a past or current officer of Blue Cross of Wisconsin.

RESOLUTION NO. 12

Introduced by

Third Councilor District Delegates

WHEREAS, The Medical Society of Milwaukee County states that it has been asked by Associated Hospital Service, Inc., to extend Surgical Care throughout the state, and

WHEREAS, This would do violence to an understanding of more than ten years' duration that the Medical Society of Milwaukee County would not intrude into counties other than Milwaukee, or where payroll originated within Milwaukee County, and

WHEREAS, The State Medical Society of Wisconsin has respected such agreement, and to this date, so has the Medical Society of Milwaukee County, and

WHEREAS, Competition between two programs both using the trade name of "Blue Shield" and both being identified as the "doctors' plans" would result in great confusion for the public as well as the medical profession, and

WHEREAS, No county medical society other than Milwaukee has any voice as to the affairs, policies or programs of its surgical care plan, and if such plan is to enter the state as a whole, professing Blue Shield and medical endorsement, then such endorsement should be at the state level, with all county medical societies having a voice in the management of its affairs;

Now, therefore, be it resolved, that: 1. Each councilor district of the State Medical Society of Wisconsin appoint a physician member thereof to serve on a statewide committee of thirteen;

2. The selection of such member be accomplished at the forthcoming session of the House of Delegates and announced at the last session thereof;

3. Such committee shall study the entire problem presented by the Medical Society of Milwaukee County in its communications, as well as such other problems of organization, economy, and preservation of principle as may be involved in the operation of both doctors' plans in Wisconsin;

4. Such committee shall have the power to organize itself, and by action directed to the Council, secure such funds as may be feasible in the conduct of its studies and the employment of special personnel shall it so deem fit; and

5. Such committee report its recommendations as soon as practical, and if advisable, recommend to the Council the call of a special session of the House of Delegates for the purpose of considering such report.

RESOLUTION NO. 13

Introduced by

Third Councilor District Delegates

WHEREAS, The joint national advertising program of Blue Shield and Blue Cross clearly separates the "Doctors' Plan" from the "Hospitals' Plan" through separate description and layout and by reference of inquiries to the respective organizations being advertised; and

WHEREAS, There is no regulation of business or membership requirement of the national Blue Shield and Blue Cross Commissions which dictates that one professionally sponsored health plan must be sold and serviced exclusively by the other, but rather affirm the importance of their functioning as companion programs; and

WHEREAS, Companion but administratively separate Blue Shield and Blue Cross plans have been successfully carried on in other states for several years; and

WHEREAS, It is fundamental that physicians, as sponsors, owners and directors of Wisconsin Physicians Service must control and direct the sales and field service activities of their own program if the people of Wisconsin are to be assured an opportunity to obtain the finest types of medical care protection; and

WHEREAS, The philosophy of companion but administratively separate Blue Shield and Blue Cross plans is currently being carried out, at least by Blue Shield of Wisconsin, through promotion, advertising, sales and similar efforts; and

WHEREAS, Only two months have elapsed since the program of Wisconsin Physicians Service began operation as an administratively distinct but nevertheless companion program to Blue Cross;

Now, therefore, be it resolved, That the House of Delegates urge the Council and the Commission on Medical Care Plans of the Society to continue such companion relationship of Wisconsin Physicians Service to Blue Cross, and to do everything reasonably possible to foster it through sales, promotion, advertising and similar efforts; and be it further

Resolved, That the House of Delegates of the State Medical Society invite the Wisconsin Hospital Association, the Wisconsin Conference of Catholic Hospitals and the member hospitals of Blue Cross to similarly urge the hospital protection plan which they endorse (Associated Hospital Service) to reciprocate in support of Wisconsin Physicians Service as a companion plan.

RESOLUTION NO. 14

Introduced by

Eau Claire–Dunn–Pepin County Medical Society

WHEREAS, County public welfare departments in this state use schedules which while differing in amounts also differ in terminology and arrangement, and

WHEREAS, Many physicians find themselves dealing with the clients of more than one county, and the variation in procedure, amounts, and terminology causes confusion and increases administrative difficulties.

Now, therefore, be it resolved, That the State Medical Society be requested to develop a recommended schedule comparable to Blue Shield schedules for use by all county welfare departments in this state.

Report of the Council . . . . . by R. G. ARVESON, M.D., Chairman

The Council of the State Medical Society is, by Constitution and Bylaws, its principal executive body between sessions of the House of Delegates. Its work and its responsibilities have become increasingly complex to a point that upon recommendation of the chairman, there has been a reorganization within the functioning level of the Council itself. Five committees have been created: Scientific, Planning, Finance, Economic Medicine, and Executive. The chairmen of the first four committees and the chairman of the Council, plus the president and president-elect as ex officio members, constitute the Executive Committee.

There have been only two regular meetings of the Council since this process was brought into being. The total agenda is distributed to the entire Council, with each item coming before it for action having first been reviewed by an appropriate committee; so at the time of Council action, the recommendations of its committee in the particular area of concern are made known to the entire Council. This assures that about 25 per cent of the councilors will have fully screened each item upon the agenda, and when the entire Council meets to review these items, it will have the benefit of their more detailed knowledge and consideration.

In the process of this reorganization, the Council finds some clarification or changes needed in the bylaws.

Chapter VI of the bylaws now calls for the annual meeting of the Council to be held in January of each year. The Council recommends that Section 6 be amended to permit the Council to establish the date of its annual meeting, so that the sentence would read (material proposed for deletion in parentheses): "The Council shall adopt an annual budget providing for the necessary expenses of the Society, which shall be prepared and presented for its consideration by the treasurer and secretary at the first meeting of the Council (in January of) each year."

Second, there is no specific bylaw provision permitting the Council to create other titles within its organization, (although there is reference to a "chairman" and bylaw provision for election of a secretary). At the present time, the Council has created by informal action two positions of assistant treasurer to facilitate the handling of the multitude of affairs that now come before officers for signatures.

The Council recommends that the bylaws be so amended as to permit it to create the position of vice-chairman and such offices as may from time to time be indicated to facilitate its organization and the discharge of its duties. This would be accomplished by adding a final sentence to Chapter VI, Section 6 reading: "The Council may elect a vice-chairman and create such further offices, or combine or abolish them as it sees fit in the management of its affairs and in the discharge of its responsibilities."

Speaker Hildebrand has suggested to the Council, which agrees, that Chapter XI, Section 8, requiring county medical societies to report names of their delegates should be amended to require such reports to be made by the end of the calendar year preceding the year in which such delegate is elected to serve. Delegates and county secretaries are reminded that terms of delegates shall be for a full calendar year. Delinquency in reporting defeats the purpose of maintaining a current roster of delegates at all times.

There will be further reports submitted by the Council at the time of the annual meeting. However, as chairman of the Council, I feel it important to emphasize its wide area of responsibility and activity.

The Council, as the principal executive body between sessions of the House, feels its duty to report periodic surveys of projects both those contemplated and in process.

It reports to the House:

1. Staffing for the program of hospital relations was completed in 1957, and the mandate of the House in that respect has been met. Further information will be provided through the Council on Medical Service and the Committee on Hospital Relations as their joint efforts in this direction are more completely defined.
2. Frequent economic studies complain of the costs of "medical care" without appreciation of what the term means to those gathering statistical information. It has been the constant effort of the Council to seek a separation of the costs of physicians' care as distinguished from an all-inclusive term that, in many studies, embraces the costs of such items as hair tonics and patent medicines. A current project in that direction is now being undertaken in connection with statistical reports dealing with experience under the Workmen's Compensation Law.
3. Current joint efforts with a committee of the State Bar of Wisconsin are now underway to ascertain if there is some model provision which may be recommended to hospitals as to the availability of hospital records relating to patient care.

NECROLOGY REPORT

The Council reports with sorrow the deaths of the following physicians since the last Annual Meeting. Members of the Society are indicated by an asterisk.

W. A. Smith, Boyd
*J. A. McElligott, Milwaukee
C. E. Garner, Richland Center
E. C. Lippitt, Milwaukee
*E. P. Webb, Beaver Dam
*M. V. Pirsch, Kenosha
*C. J. Skwor, Mishicot
*G. H. Fellman, Whitefish Bay
H. C. Meyer, Necedah
A. L. Bockhorst, Milwaukee
D. H. Eurit, Argyle
*W. N. Linn, Oshkosh
*C. J. Brady, Lake Geneva
*S. M. Mokrohisky, Green Bay
*V. F. J. Bruder, La Crosse
*M. A. Borchardt, New London
*W. G. Bear, Monroe
*W. J. Ganser, Madison
C. J. Doyle, Grafton
W. A. Bates, Madison
G. F. Messer, Milwaukee
*L. E. Schmidt, Wausau
*M. E. Van Vleet, Milwaukee
*V. F. Lang, Milwaukee
*L. H. Donath, Wauwatosa
*J. A. Hurlbut, Madison
A. L. Herron, Milwaukee
E. A. MacCornack, Boulder, Colo.
H. L. Wilkerson, Crivitz
L. R. Fowzer, Milwaukee
W. F. Lorenz, Madison
J. E. Reichert, West Bend
*S. C. Allen, Waterloo
*J. B. Ozonoff, Milwaukee
*M. A. Santilli, Milwaukee
*H. J. Kuhn, Milwaukee
*W. C. Verbrick, Little Chute
*A. A. Teitgen, Manitowoc
*V. C. Kremser, Amery
*W. J. Voellings, Mukwonago
*J. J. Werner, Milwaukee
*T. S. O'Malley, Milwaukee
*H. W. Powers, Milwaukee
*F. A. Boeckman, Marshfield
W. F. Groth, Pickerel
*O. O. Nelson, Madison
*J. A. Schindler, Monroe
E. L. Gilman, Mellen
*J. C. Devine, Fond du Lac
*D. R. Peterson, Independence
*D. W. Roberts, Milwaukee
G. C. Werner, Indianapolis, Ind.
A. L. Olson, Stoughton
J. D. McAtee, Tuscaloosa, Ala.
*P. F. Brey, Milwaukee
*H. C. Ladewig, Milwaukee
*Charles Fidler, Milwaukee
*Christine Ivanov, Milwaukee
*G. H. Reddick, Wabeno
C. F. Hardy, Milwaukee
B. P. Churchill, Milwaukee
L. L. Weissmiller, Rutland, Mass.
E. S. Sullivan, Madison
R. R. Rath, Granton
*H. T. Hansen, Milwaukee
*T. J. Snodgrass, Janesville

4. At some point in the next several years a complete study of laws relating to the State Board of Health, its organization, duties and functions will be undertaken. Many of these statutes are of years standing and are now either obsolete or antiquated.
5. During the past year the Council has instituted a news letter to county society officers, delegates and others to summarize important interim developments which should not be delayed for Journal printing.
6. A comprehensive Medical–Press–Radio–TV Guide is well along the road to completion.
7. In cooperation with other organizations, the Society is discharging a public health responsibility in surveying and exposing by report cancer quackery in Wisconsin.
8. In 1958 there will be a fine institute on high school athletic competition and injuries, to be held in November in Milwaukee.
9. A state-wide symposium on the health hazards of chemicals is in process.
10. "Physical Examinations of Industrial Workers," published first in 1938, is now in process of revising and reprinting.
11. Already distributed is a compendium of materials which can serve as a practical guide on nursing homes for county medical society use.
12. In the area of mental health, care and treatment of the emotionally disturbed child is one of the major problems.

This list is submitted to illustrate, not to enumerate, the many projects with which this Society is concerned.

You will note from other contents herein that most of these projects are described in detail. To those unacquainted with Society procedure it might appear that there is complete decentralization of the policy direction of Society affairs.

That is not the case.

Any project requiring financing must be cleared through the Council and its Finance Committee. If such project should be consequential in amount, it more likely will be referred to the House of Delegates as were proposals of recent years in implementing field service, in furnishing the Grievance Committee with adequate funds, and as the case of a year ago, the recommendation relative to hospital field service.

By provision of Chapter VI, Section 3, the Council serves as the Board of Censors and considers, in that capacity, questions of an ethical nature.

A frequent question submitted by various medical societies relates to the availability of records to

a successor physician in practice. The Council during this past year approved the following statement by the Secretary as correctly stating the ethical considerations involved:

"I think it is generally agreed that the confidential character of these records is between the patient and the physician who served him and that they should not, without express or implied consent, be turned over to the attention of a successor physician. I believe it has been customary in some areas for a physician to announce to his patients that he is retiring from practice and that his offices will be occupied by a physician, whom he may identify briefly, as of such and such a date. The records in his possession may possibly have value in subsequent treatment of the patient and unless he hears to the contrary, they will be left in custody of the successor physician, but he will be glad to forward them to any other physician should the patient so desire."

In addition, the Council formally adopted the following statement on ethical considerations in employment of ancillary personnel:

"A problem which is frequently presented to the Secretary's office, or to a committee, involves the practice in some areas of indicating ancillary personnel associated in a physician's practice. In some instances such ancillary personnel, engaging in a limited practice and on 'free lance' basis, establish their own office but share certain facilities, such as a waiting room, with a physician and surgeon. 'Ancillary personnel' includes those engaged in the fields of podiatry (chiropody), physical therapy, in some cases optometry, clinical psychology, and others. As used in this statement, 'ancillary personnel,' does not refer to the practice of dentistry.

"The Council of the State Medical Society of Wisconsin has not recorded formal action upon these inquiries in the past, but has known of informal advice that the *employment* of such individuals by physicians, and for the purpose of utilizing their training under physician direction for patient care, is not unethical.

"But physicians have been advised that designation of these individuals on letterheads, on professional announcements, or in the physician's office itself, is improper.

"Such practice has been felt objectionable on the basis that it may well create in the minds of the patient that these individuals are of training comparable to that of the medical profession and have achieved a professional equivalency. It is further objectionable in that publicizing such affiliation tends to at least indirectly constitute a 'puffing' of the physician's facilities in comparison to those of others who do not have such facilities or services in their immediate practice.

"It follows, then, that where there is no employment involved the sharing of a common waiting room, or in some other manner publicly associating one of limited skills with a physician and surgeon, are also improper. This constitutes an indirect violation of the same principle enunciated in the case of employed ancillary personnel."

This concludes the formal report of the Council. Delegates are reminded that the Council's most important actions are bulletined by means of the Councilors and Officers Newsletter, while printed minutes of its meetings and articles in the Forum section of the Journal serve further to advise the membership of its principal actions during the course of the year.

Report of the Secretary . . . . . by Mr. C. H. CROWNHART

It has been our experience of recent date to become more conversant with the jargon of the professional, federal government administrator as we negotiated and entered into administration of Medicare. The office has learned that the word "finalized" means that a particular document has reached a state of completion as to a particular office, but "final" does not mean final; it only means that that particular office seems to have no further ideas such as had previously been "cranked in," as the process is known, of inserting a new thought or a new device. Any administrative or policy problem must be brought into proper "focus" to be fully understood. Letter number so and so is only "interpretive," but on close reading is found to contain substance either at variance with or in great elaboration upon some provision in the so-called "completed" document which has now cleared all administrative agencies. A rule stated with apparent finality to one state is handled much more liberally in another, and once again the office of the secretary is brought to sharp and stern realization of what it means to have the government enter into the pattern of control, quality, and character of medical practice for certain individuals who are placed in a category of being wards of the nation.

So I deviate from the more customary secretary's report to emphasize to the members of the House, and through the House to the members of the Society that I think we have reached a point where we should lay aside for the moment some of our current problems, and try to analyze where we have been and where we are going. The future of medicine must ever be a real responsibility.

Your office is essentially an administrative one. Question after question comes to it: a community

that wants a doctor; a doctor who wants an associate; legal matters; hospital staff problems; authentic information as to a particular drug or its method of distribution; the responsibility of the profession in mental health and other programs. Several hundred of these are received in the course of a month. They cannot all be answered on the spur of the moment. Often research, study and correspondence is involved. No meeting is held for which there is no preparation. There is assigned to the office the gathering of statistical information upon which committees may reach conclusions . . . or the highly skillful work being done as exemplified in the maternal mortality studies.

We are faced with deadlines, as in the medical profession. One annual meeting is no more than over before preparations are begun for another. Periodically, the open panel distribution must be made. The Journal is "put to bed" on a schedule as inexorable as that so frequently applied to a newborn babe.

Sometimes it seems to the secretary that he and the staff are almost in the position of the driver in a blinding snowstorm. The flakes come so heavy and so thick that eyesight becomes more and more myopic.

But in an effort to emerge into the bigger and broader planning which must be made not just in the months but in the years ahead, let me point out, perhaps only in vague manner, some of the consequential programs I feel will confront medicine, in some alternative, in the next decade:

First, as our country has become increasingly paternalistic, so tend some of our professional associations. Some types of insurance protection are written either on a true or pseudo-group basis. It is possible for physicians of Wisconsin to purchase an excellent income protection plan through membership in the State Medical Society. The physicians can secure, on a semi-group basis, the benefits of Blue Shield and Blue Cross. Beginnings have been made upon what amounts to a form of group life insurance, and sometime in the future I see this latter program being translated into a mechanism whereby physicians can join in developing not only an income protection plan, but a retirement program adequately managed and devised for their needs. And out of this welter of protection by group devices may come about other possibilities, which leads your secretary to the belief that in some manner there will ultimately be created a division of business services to the profession as a whole, available on choice, and on cost reimbursement, to those who desire its services.

The economic field presents substantial problems as a result of current changes in the social security law giving impetus to direct grants to recipients under certain public welfare aids. The problem of insuring the aged concerns the public in general as well as the profession specifically, and you will hear much of it in the next several years. Does that portend the possibility of a division of activity within the Society related solely to the field of public assistance, aiding in the development of adequate schedules of benefits, or perhaps carrying into that field some of the philosophy that has been conceived in the Special Service Contract of our Blue Shield plan?

There is an area of special sorrow to me.

One cannot have been associated so long or so intimately with the medical profession without having acquired in those years personal friends and a deep sense of loyalty and confidence in the practicing physicians as a group. When adversity strikes some one of these individuals and he becomes destitute either as to funds or friends, it seems to me that the fraternal spirit which is basic to any profession must in some manner exhibit itself. A fraternity takes care of its own. More mundane matters should be laid aside while the others rally to protect the individual who suffers such a catastrophe. Programs in that area for the protection of members of the medical profession must come into reality in the very near future.

MEMBERSHIP REPORT

(As of December 31, 1957)

Members paying no dues		169
Affiliate members	58	
Military service members	28	
Honorary members	8	
Life members	54	
Transfer members	21	
Total	169	
Members paying pro rata dues (military service and new members after July 1		45
Associate members		47
Members in residency training		156
Members paying full dues		3007
Educational members		6
Total Membership		3430

Out of this myriad of activities and the future responsibility of medicine, particularly in the field of medical education, comes also that grim realization that nothing can be fully accomplished without sufficient wherewithal to do the work. Your secretary appreciates that the dues of the State Medical Society of Wisconsin on a per capita basis rank high among those of other state associations. He would point out, however, that many other state associations have much larger numbers of physicians paying dues to their state society. The dues being paid in 1958 cannot be viewed, except in some cases, as of an amount consequential enough to be a hardship to the physician. But it is true that, like

many taxes, they come but once a year and during the season when the physician is rallying from the impacts of an overabundant Christmas spirit, of a toting up of last year's experience, and of the somewhat unpleasant realization that income tax time is near at hand; also that the "kid" needs more funds for the second semester of college and the automobile is now a year older. Perhaps the continuing value of a state medical association will be reflected in more periodic billings of dues so as to level their impact over the course of a year, and particularly will this be the case if the Society enters an area of true group insurance and retirement programs for the benefit of its members. Total benefits of membership may be of sufficient monetary value as to warrant quarterly or even bimonthly payment of dues at some relatively near date in the future.

During this past year your secretary can report that there has been no slackening of effort, and while some functions have been regeared and some retooling has been accomplished, there remains that steady driving impulse to forge ahead as a state medical society with realistic, liberal, and well-organized leadership.

REPORT OF THE COMMITTEE ON PUBLIC POLICY

Since the very earliest days of the State Medical Society of Wisconsin, medicine has used its influence to improve standards of medical education, further research, establish sound public health programs and facilities and "secure the enactment and enforcement of just medical laws." Here are but a few of the major health issues in which the Society played a leading role in convincing the Wisconsin legislature that their enactment would serve the public good:

*The beginning of conferences to establish State University Medical School, 1850.

*Pleas for the establishment of a hospital for the insane, 1856.

*Requests for better care of imbeciles, blind children and feeble minded, 1867.

*Establishment of the State Board of Health, 1876.

*Beginning of tuberculosis control, 1883.

*Creation of State Board of Medical Examiners for licensing, 1897.

*Creation of nation's first basic science law, 1925.

*Free choice of physician under Workmen's Compensation, 1932.

*State Medical Grievance Committee created, 1935.

*Voluntary sickness insurance plans begin, 1938.

*Revision of commitment laws, 1955.

There are many more. Each represents a significant public health advance. Yet most were achieved against considerable odds and opposition, often after repeated attempts at public and legislative persuasion.

Today the legislative problem is basically unchanged from that faced by medicine a hundred years ago. Now, as then, medicine's legislative activity rests on a single premise: what is good for the public is good for the doctor. Now, as then, the most urgent need is for greater application of that fundamental of practical politics which the newspaper columnists call the "grass roots approach."

The president of the Racine County Medical Society, Dr. L. M. Lifschutz, expressed the problem very well in a recent address to his society members:

> ". . . I need not go into the inroads on our status as free practicing physicians that are being attempted in Washington with bills concerning government care for all those eligible for social security and welfare. I need not go into the new policy of state welfare agents who are making it mandatory that the recipients of welfare sponsored medical care receive the money directly for the medical bills incurred. Then there are chiropractic bills that *almost* pass. With our position and status being continuously threatened at these high levels, and our leaders fighting what appears to be a slowly losing battle, what are we at the grass roots level of medical practice and at county medical society level doing to help? It is not inconceivable that with a minimum of help from us, our leaders might gain more lasting and definitive results.
>
> "Let us take one point as an *example* at this time. A recent chiropractic bill before the State legislature was, without going into details, designed to increase their privileges, expand their activities and in general elevate their status to that which closer approximated that of the doctors in the healing arts. We had to scurry around at the last minute, and those who were most active in this endeavor were forced to resort to persuasion and salesmanship in its most obtuse form to defeat the bill, sponsored by these bone cracking, back twisting charlatans.
>
> ". . . Even though they are licensed and the legality of their existence cannot be questioned, the issues of their worth and their value from the standpoint of health in this country is still a line of attack open to us in which we can subtly engage. Such attack if adequately and sensibly handled could markedly expose their position as being based only on the fact that they are legally licensed. With this concept only,

many facets of public relations improvements could be accomplished. There is no reason why we who are disciples of many long years of medical background, tradition, accomplishment and unquestioned achievement should have to worry on which side legislators will align themselves.

"Continuing this example, let us realistically observe our public, our constituents whom we must orient from the standpoint of our value to them, as compared to the value of cults in general . . . Let us face it. From my experience the teaching of anything concerning medicine to them is out of the question. We run into some type of impenetrable block. We can only hope to take the knowledge that they have submerged into their mental limbo, and channelize it to cerebral level. This is feasible. They know and see football players tackled and thrown hard, wrestlers thrown across rings, people struck by cars and with their own medical hearsay experience, they know that simple vertebral displacements are an extremely rare phenomenon. Knowing all this they keep chiropractors busy replacing their "misplaced" vertebra. We cannot teach them but we can channel what they do know, call it to their attention in a subtle manner so that a substantial amount of insight can be stimulated.

". . . Our basic problem in public relations has to be attacked on two fronts and this can be done concurrently and reciprocally. It cannot be done by political speeches. The public has to have some orientation and our legislators have to have some orientation, but for that to stick we must give them insight and place them in a position where they can at least do some constructive thinking. I repeat this can be accomplished without any thought of trying to teach anybody anything. Luckily, we have a background of past accomplishment which people know about and which we can use without any attempt at overt or groundbreaking salesmanship; by merely calling to their attention what they already know and . . . give our constituents a chance to develop some medical insight . . ."

In essence, Doctor Lifschutz proposes a grass roots approach by physicians to their patients and to legislators to help them know and understand the need for protection against quackery and cultism; the necessity for fundamental scientific approach to health problems.

This is the philosophy of the Committee on Public Policy. It is the core of its program in the years ahead. Already, the county societies have caught this spirit. Almost every society has re-activated its public policy committee or similar mechanism. The state committee plans a series of informative bulletins on major health issues to all county committees, officers, delegates and woman's auxiliary committees. During the 1959 legislative session each county society will be kept informed by regular bulletins from the State Society office. The following bulletin is typical of what is contemplated.

LEGISLATIVE BULLETIN

COMMITTEE ON PUBLIC POLICY, STATE MEDICAL SOCIETY OF WISCONSIN

APRIL 1, 1958

HEARINGS TO START ON FORAND BILL

Hearings are expected to begin momentarily on the Forand Bill (H.R. 9467), an amendment to the Social Security Act. The bill proposes to provide government hospital and surgical care for an estimated 13 million persons, mostly over 65. The bill would raise the social security tax basis from the first $4,200 of income to the first $6,000. The tax rate would be increased in the hope that it would cover the cost. By 1975 the social security tax rate may reach 10 to 15 per cent of the base—or something equivalent to the federal income tax. Senator Proxmire and Representative Roosevelt have similar bills in congress, the latter would raise the tax base to the first $10,000 of income. The American Medical Association is calling for a complete analysis of social security benefits and a study of needs of the aged before instituting such a drastic step as the Forand Bill.

RETIREMENT PROGRAMS FOR PHYSICIANS

The so-called Jenkins-Reed-Keogh Bills are currently under study by congress. They would provide physicians and other self-employed persons with the opportunity for tax deferment on present income if certain portions of earnings are channeled into retirement benefit programs. The Jenkins-Keogh Bills do have their best chance in many years. If you are interested, write your Congressman.

CLINICAL PSYCHOLOGISTS TO TRY AGAIN The Wisconsin association of clinical psychologists have indicated they will go to the Wisconsin legislature in 1959 with a proposal for licensure. The Society, as well as the American Psychiatric Association and the American Medical Association, have opposed licensure for ancillary personnel. Limited license is misinterpreted by the public as broad professional competence and invariably results in later requests for expanded privilege.

TREATMENT CENTER FOR DISTURBED CHILDREN Although it is too early to predict specific proposals, the Wisconsin Legislative Council Committee on Mental Health is almost certain to make a comprehensive report to the 1959 legislature. A major item is a treatment center for emotionally disturbed children. The Medical Society feels the need for a medically oriented institution on the University campus to facilitate education and research.

CHIROPRACTIC EFFORT ANTICIPATED AGAIN The State's Attorney General won a test case in Kenosha with a decision that chiropractic is limited to adjustment of the spine by hand. Recently the State Board of Medical Examiners has begun prosecution of chiropractors for use of the title "Dr." Chiropractors can be expected to push the Kenosha decision to the Supreme Court. Also expected is a strong attempt in the next legislative session to achieve by legislation what chiropractic has not been able to achieve by education or court decision. There is no backdoor to the practice of medicine. This is something the profession must impress upon the public.

Medicine is not an economic giant with ample funds to buy influence—if it were, it could not in good conscience do so. Neither is it a numerical giant with enough votes to command attention. Medicine rests its case on what it believes is scientifically sound and good for the public well-being. Every physician can respect that policy and support it with his personal effort. This Committee will do its best to disseminate information. You, the physicians, must establish personal contact with your legislative representatives to place the facts before them. With your cooperation, the Committee has faith that the public health and well-being will be adequately served by the Wisconsin legislature.

Respectfully submitted,

A. A. Quisling, M.D., Madison, *Chairman*
J. R. Schroder, M.D., Janesville
J. P. Conway, M.D., Milwaukee
S. E. Gavin, M.D., Fond du Lac
J. M. Sullivan, M.D., Milwaukee
Earl C. Quackenbush, M.D., Hartford
Robert G. Zach, M.D., Monroe
H. E. Kasten, M.D., Beloit, Ex Officio
J. W. Fons, M.D., Milwaukee, Ex Officio
C. H. Crownhart, Madison, Ex Officio

REPORT OF THE COMMITTEE ON CANCER

The first state-wide effort in America to discover uterine cancer through cytologic screening in the doctor's office is being attempted in Wisconsin. Your Committee has worked closely with the Wisconsin Division of the American Cancer Society and the Wisconsin State Laboratory of Hygiene in developing this program. It heartily endorses and supports this effort to train cytotechnologists, establish cytologic screening centers in cooperation with county medical societies and carry on programs of professional and public education on the value of cytologic screening as a technique for the detection of uterine cancer.

The success of the program hinges on two things:

1. Training of a sufficient number of technicians (cytotechnologists) to place them throughout the state at various medical centers.
2. Patient and physician cooperation in applying the Papanicolau tests routinely to every woman in the state twenty years of age or older.

The first step is already underway. The State Laboratory of Hygiene has set up a technician training program of six months with two courses each year. Six to ten qualified candidates may be trained in each session. Trainees will receive $225 per month while at Madison, through a program of federal aid. County medical societies are urged to recruit suitable candidates for the course to assure themselves of having competent personnel to handle reading of the slides. The Wisconsin Society of Pathologists is cooperating in establishing adequate screening centers.

The second phase of the program relates to professional and public education as to the necessity of routinely performing the cytologic screening. The subject is being brought to the physicians through the county medical societies and to the public

through an educational program of the Wisconsin Division, American Cancer Society featuring a film entitled "Time and Two Women" with talks by physicians to answer specific questions.

Your Committee on Cancer will be pleased to provide advice and information on the establishing of a cytologic screening center. In addition, it makes available information on the establishment of cancer registries.

County medical societies are urged to take advantage of program material on "Emotional Aspects of Malignancy." Speakers and films are available from the State Medical Society in cooperation with the Wisconsin Division of the American Cancer Society. At the same time, the two groups are cooperating in a program of detection and public education in cancer quackery, development of a television kinescope and a traveling exhibit through funds provided by the Wisconsin Division.

Respectfully submitted,

R. C. CANTWELL, M.D., *Chairman*, Shawano
A. R. CURRERI, M.D., Madison
R. B. LARSEN, M.D., Wausau
W. S. BUMP, M.D., Rhinelander
E. C. HOWELL, M.D., Fennimore
RALPH C. FRANK, M.D., Eau Claire
R. J. SCHACHT, M.D., Racine
G. I. UHRICH, M.D., La Crosse
CARLTON WIRTHWEIN, M.D., Milwaukee
P. B. BLANCHARD, M.D., Cedarburg
R. P. WELBOURNE, M.D., Watertown
PAUL M. CUNNINGHAM, M.D., Appleton
CLIFFORD A. GRAND, M.D., Ashland

REPORT OF THE COMMITTEE ON HOSPITAL RELATIONS

"Because of what this Joint Committee has learned in the past year and further, because of the fact that current trends indicate a more complicated hospital-physician relationship in the future, these committees recommend that immediate steps be taken to implement full-time field service to the medical staffs of hospitals in Wisconsin."

This conclusion of the 1957 Joint Report of the Committee on Hospital Relations and the Council on Medical Service to the House of Delegates prompted the House of Delegates to order the initiation of hospital relations field service early in 1958.

Such full-time field service to medical staffs of hospitals in Wisconsin was begun in January, 1958, with the addition to the staff of Mr. Chester C. Neese, formerly hospital administrator at Cumberland, Wisconsin. His position carries the title "Consultant in Hospital Relations."

While the program has only just started and it is too early for a comprehensive report, the establishment of a full-time medical staff field service gives every evidence of being more urgently needed than had been anticipated.

In three months the Consultant in Hospital Relations has traveled more than 7,000 miles visiting physicians and administrators of thirty hospitals. His services are proving of considerable value both to administrators and medical staffs and the committee believes that his efforts will enable it to provide a substantial review of physician-hospital relationships in Wisconsin for the House of Delegates session in 1959.

Typical of the situations encountered in the field service activity are the following:

Hospital A—Staff bylaws antiquated or nonexistent on many points. Poor bylaws and lackadaisical participation in staff meetings have combined to present serious problems of discipline of the medical staff and confused administration. As a start toward solution the medical staff is now meeting regularly to develop a completely new set of staff bylaws with the assistance of the Consultant in Hospital Relations. In itself this joint effort of physicians has lifted morale and heightened interest in proper administration of the hospital.

Hospital B—Physician-administrator relationships had developed to the point of rebellion because the public was blaming physicians for high hospital costs on the basis of poorly prepared hospital bills. The hospital bills to patients provided nothing more than the total hospital charge for the stay. Physicians had pleaded without result for itemization of hospital charges. The Society's Consultant arranged a meeting of the staff with executives of the hospital board and the administrator and developed a new hospital billing form and other mechanisms for establishing improved public relations with regard to hospital charges.

Hospital C—Administrator and board disputed policies established by the medical staff, and the administration purchased medical-surgical supplies without professional advice. For example, routine chest x-rays established by medical staff action were cancelled by the administrator without consultation with the staff. Improper and inferior supplies purchased by the administrator could not be used. There is no clear liaison between the medical staff and the board although the staff meets regularly. Meetings with the staff have been directed toward establishing clear cut and regular liaison between the staff and the board and in educating medical staff and administrator in their responsibilities for hospital operation. This is largely an educational and informational effort so that both will have a better appreciation of adequate and proper operation of the hospital.

Hospital D—An administrator made the first contact concerning a series of questions including: when are consultants necessary; who may serve as an assistant or consultant; what records are required of consultants' services in such procedures as D & C; sterilization and other OB-GYN procedures? Staff reply was directed to the medical staff of the hospital as a matter of policy. Subsequently the medical staffs bylaws were revised and an improved relationship developed between the staff and the administrator.

Questions, inquiries and problems encountered run the entire gamut of physician-hospital relations. The most common problems relate to professional education and conduct of medical staff meetings, liaison with hospital boards, staff discipline, medical records, staff privileges, dentists on hospital staffs, hospital administration, hospital expansion, costs of care in hospitals, nursing and technician staff problems, establishment of lay advisory boards, routine admission procedures, employment of the administrators, news relationships, policies on radiologic and pathologic procedures, autopsies, and disaster programs.

Medical staffs should insist on a periodic review of their hospitals' staff bylaws. Although the model bylaws of the Joint Commission on Accreditation of Hospitals are generally applicable, there appears to be a need to prepare modifications for the peculiar needs of some communities. Bylaws carefully and thoughtfully prepared have a prophylactic effect as well as providing the base for relatively smooth and satisfactory settlement of disputes and other problems.

Your Committee is thoroughly satisfied that the Society's activity in the area of field service to medical staffs is a sound investment in substantial service to every member of the Society.

Respectfully submitted,

W. C. Henske, M. D., *Chairman*, Chippewa Falls
W. B. Hildebrand, M. D., Menasha
A. J. McCarey, M. D., Green Bay
S. W. Hollenbeck, M. D., Milwaukee
A. H. Barr, M. D., Port Washington
S. R. Beatty, M. D., Neenah

REPORT OF THE COMMITTEE ON DIABETES

The most important need in the field of diabetes today is education of the diabetic to care for himself. This can be done in two ways—by helping physicians to do a better job of educating their patients, and by going directly to the patient through public education.

Your Committee on Diabetes feels that a great deal can be done in both areas and it proposes to implement this effort in the following ways:

1. The general theme of "How to Handle Diabetes" should be emphasized in circuit teaching programs, round table discussions at the Annual Meeting, development of a speaker service to county medical societies in cooperation with the Wisconsin Diabetes Association and by editorials and papers in the *Wisconsin Medical Journal.*
2. Postgraduate courses should reduce emphasis on control from the standpoint of blood sugars and increase emphasis on patient-testing of urine for sugar and the resultant self-control.
3. Medical society participation in National Diabetes Week in 1958.
4. Emphasis should be placed on education of the patient and physician rather than the organization of detection programs.
5. Physicians should urge their diabetic patients to subscribe to and read "Forecast", a monthly publication of the American Diabetes Association which is prepared for non-medical readers at a cost of $2.00 per year.
6. During the 1958 National Diabetes Week, the State Medical Society is urged to use its "March of Medicine" radio programs, newspaper releases, articles in the *Wisconsin Agriculturist and Farmer*, spot radio announcements and health news releases to business and industry to emphasize patient understanding of the control of diabetes.

Publicity is being developed to physicians to make them aware of the availability of diabetic camps in Wisconsin for boys from age 6 to 18 and for girls from ages 9 to 16. Although accommodations are limited, opportunities are available for about 70 persons to utilize these camps.

Physicians attending the Annual Meeting are urged to visit the Committee's exhibit in the Auditorium which has been prepared in cooperation with the Wisconsin Diabetes Association.

Respectfully submitted,

Karl H. Beck, M. D., *Chairman*, Wauwatosa
Maurice Hardgrove, M. D., Milwaukee
N. A. Hill, M. D., Madison
James P. Conway, M. D., Milwaukee
A. H. Heidner, M. D., West Bend

REPORT OF THE COUNCIL ON SCIENTIFIC WORK

Medicine, perhaps more than any other profession, is subject to constant change. Change, born of research and experience, is the catalyst for the multivaried activities of the Council on Scientific Work. As the body of scientific knowledge grows, it is inevitable that the physician will devote an increasing proportion of his time to the adjustment of his therapies to the dictates of the medical educator.

That the physician gives this time so fully and willingly is a source of greatest satisfaction to this Council. So many opportunities for postgraduate training are open to the physician today, yet the fruits of this Council's labors are abundant. Witness the excellent attendance at the Society's Annual Meeting in 1957—more than half of the practitioners in the state accepted this offering of food for scientific thought.

Attendance in the circuit teaching clinics declined somewhat over previous years. Even so a total of 600 physicians registered—nearly 30% of the membership for which these clinics were created. Like the old saying, however, one clinic's loss is another clinic's gain. Other scientific programs under the Society's sponsorship have mushroomed to accommodate special interests and obvious needs. Two inhalation therapy institutes presented by the Society's Charitable, Educational, and Scientific Foundation attracted 125 physicians. The prematurity institutes under the direction of the Society's Division on Maternal and Child Welfare have been highly popular with more than 300 attending two sessions early in 1958.

Numbers alone, it should be emphasized, are not the sole or perhaps even the major criteria for success in postgraduate education. We are satisfied that the answers to other questions provide an equal if not greater estimate of value:

> Does the clinic reach physicians whose geographic location limits access to regular programs?
>
> Does the clinic replace or augment hospital staff programs in the smaller institution?
>
> Is the subject matter of wide or limited appeal?
>
> Is the teaching material transmitted by those who attend to a wider audience of colleagues through later daily contact?

As in the past the Council on Scientific Work devotes considerable of its efforts to evaluation of the various programs being offered and consideration of other means by which physicians in Wisconsin can be kept abreast of the latest scientific developments.

The Annual Meeting program this year follows the pattern established some time ago with a mixture of specialty meetings and "general practice day." Collaboration of the general practice and specialty groups within the State Society has provided leadership for the development of a fine, well-balanced program. This format seems most effective and should be repeated.

Four circuit teaching programs will be offered in the academic year of 1958–59: October, November, January and February. Faculty members of the two medical schools will be used increasingly as circuit staff. The dinner program will be eliminated and a complete program presented between 1:30 and 6:00 P. M., providing time for questions and discussion in the latter part of the afternoon.

Recognizing that in many areas the major avenue for scientific medicine is the hospital staff, the Council is exploring a type of teaching which might best be described as a hospital consultation service. Under a pilot program at least two hospital staffs will be offered an opportunity to utilize the services of two faculty members from Marquette or the University of Wisconsin for one or two full days. This would provide a morning CPC and direct bedside teaching. The pilot program in two hospitals will be evaluated and reported to the general Council in 1959.

The Council on Scientific Work is anxious to be of greatest service to the greatest number of members. It frankly solicits the comments and suggestions of all members on subject matter, faculty and teaching methods which can be useful in extending medical knowledge to the profession of Wisconsin.

The Council also invites your attention to the *Wisconsin Medical Journal* as one of the strongest arms of scientific medicine in the Society. Its report, on the reverse side, is brief but most interesting.

Respectfully submitted,

L. G. Kindschi, M. D., *Chairman*, Monroe
K. E. Lemmer, M. D., Madison
M. F. Huth, M. D., Baraboo
M. C. F. Lindert, M. D., Milwaukee
R. S. Baldwin, M. D.,Marshfield
J. Z. Bowers, M. D., Madison
J. S. Hirschboeck, M. D., Milwaukee
Roy B. Larsen, M. D., Wausau

REPORT OF THE EDITORIAL BOARD

As an educational effort few if any of the Society's activities rival the *Wisconsin Medical Journal* in the successful distribution of scientific knowledge to all the members. Its editorial, public relations, economic and organizational sections make an additional contribution to a well-knit, well-informed profession.

A few months ago each member of the Society was queried by mail as to his opinions of the Journal and its usefulness to him. The results were surprising—nearly 1,400 questionnaires were returned.

The consensus was highly reassuring to the effect that our Journal was being read, and that it fills an effective role in postgraduate medical education first, and a bond of fraternalism, second.

Many suggestions were offered which will be helpful to the Board in a proposed review of the Journal for future continued improvement.

Respectfully submitted,

R. S. Baldwin, M. D., Medical Editor, Marshfield
J. M. Sullivan, Editorial Director, Milwaukee
D. W. Ovitt, M. D., Milwaukee
Elwood Mason, M. D., Milwaukee
Frank Weeks, M. D., Ashland
G. A. Cooper, M. D., Madison
V. S. Falk, M. D., Edgerton

REPORT OF THE COMMITTEE ON COORDINATION OF MEDICAL SERVICES

Since the early thirties the Committee on Coordination of Medical Services has played an influential role in the development of the Wisconsin General Hospital as an institution for the training of medical students and a center for service to the public and the profession.

Once again the Committee is challenged during a period of reorganization of the hospital and the medical school to lend its assistance for the maintenance of high standards of training and care and to expand the ability of this institution to provide more effective service to the people of Wisconsin.

The problems of the Wisconsin General Hospital and the University of Wisconsin Medical School are many and complex. In the past year there have been three meetings of the Committee with representatives of the University of Wisconsin, the Medical School, Wisconsin General Hospital, the Dane County Medical Society and others. At least two additional meetings are contemplated before the House of Delegates meets in May.

By way of background of the problems of the University of Wisconsin Medical School and the Wisconsin General Hospital the Committee presents a recent series of articles from a Madison newspaper. (The series of articles appeared in the Capital Times starting January 6, 1958, and continuing through January 11, 1958.)

A more complete and detailed report will be presented by this Committee at the first session of the House.

Respectfully submitted,

R. S. Gearhart, M. D., *Chairman*, Madison
Maurice Hardgrove, M. D., Milwaukee
R. B. Larsen, M. D., Wausau
J. W. Nellen, M. D., Green Bay
H. E. Oppert, M. D., Viroqua
E. J. Nordby, M. D., Madison
S. E. Gavin, M. D., Fond du Lac
L. W. Schrank, M. D., Waupun
J. F. Wilkinson, M. D., Oconomowoc
J. H. Wishart, M. D., Eau Claire

REPORT OF THE COUNCIL ON MEDICAL SERVICE

The clash between the "right to know" as viewed by the newsman on the behalf of the public and the "right to privacy" as viewed by the physician on the behalf of his patient is not infrequently the cause of tense relationships between physicians and newsmen. Both views have their place. Both practitioners are bound by established principles of ethics which have grown out of the tradition and requirements of their respective callings. It is clear that each must honor the natural commitments of the other.

When the source of news is a doctor or his patient, the press assumes an obligation to consider the life and health of the patient and recognize the ethics by which the doctor is bound. At the same time news media, as important social agencies, must report medical, scientific and educational news and are entitled to the intelligent support of the medical profession and the fulfillment of this obligation.

These basic philosophies have been the starting point of a series of conferences by the Council on Medical Service with representatives of the news media in Wisconsin during 1957 and early 1958. These conferences have been informative, helpful, and enlightening. The guide to medical-press-radio-TV relationships, proposed to the House of Delegates last year, is now in its final stages. At least one conference with news media representatives is expected prior to the Annual Meeting to permit the guide to be placed in the hands of the delegates for action.

The Society's public information programs continue to expand under direction of the Council. The "March of Medicine" radio program reaches an audience estimated at more than 350,000 persons per week. The Society is deeply indebted to the 47 radio stations which carry these weekly 15 minute programs as a public service feature. The programs annually produce more than 1,000 personal inquiries from listeners to Dr. Robert C. Parkin, Assistant to the Dean at the University of Wisconsin Medical School who serves as Medical Director for the program. In addition, it produces more than 2,000 requests for copies of programs.

Simultaneously with the radio activity, the Society carries on a tape recording loan service which is utilized by nearly 100 high schools for classroom teaching. This is a modified version of the "March of Medicine" program.

Other activities of a public information nature include monthly radio spot announcements, bi-weekly articles for the "Wisconsin Agricultural Farmer", loan packets to high school and college students on medical and economic subjects, loan packets to physicians, newspaper releases, lectures to student nurses and civic clubs, preparation of exhibits and the distribution of health literature.

State Medical Society exhibit at the 1957 Wisconsin State Fair was the highlight attraction of the "Healthland" Exhibit. An estimated 60,000 to 70,000 persons viewed this exhibit on human growth and development.

A special educational effort was undertaken in 1957–1958 to distribute copies of two American Medical Association publications to the people of Wisconsin. The first of these is a "Personal Health Data Card" which is in the nature of an identification card for the billfold. It contains information concerning immunizations, blood type, diabetes, and so on for emergency use. More than 50,000 copies of this card were distributed in Wisconsin in the past year. The second item is the "Family Health Record" which is a type of diary of family illnesses, injuries, immunizations, and treatments. Nearly 100,000 copies of this pamphlet have been distributed to 4-H Clubs, Farm Bureau units, county agents, and county homemakers.

As a means of evaluating various projects to assure their value and continued economic operation, the Council reviewed the Tape Recording Loan Service and the monthly *Health News* bulletins. Both were found to be in great demand and authoritative reports indicate that the Tape Recording Loan Service is the only one of its kind serving the State of Wisconsin and as such fulfills a unique purpose.

Respectfully submitted,

J. S. Devitt, M. D., *Chairman*, Milwaukee
W. J. Fencil, M. D., Monroe
D. M. Willison, M. D., Eau Claire
E. C. Cary, M. D., Reedsville
J. F. Maser, M. D., Rice Lake
C. J. Picard, M. D., Superior
R. L. MacCornack, M. D., Whitehall
D. E. Dorchester, M. D., Sturgeon Bay
H. J. Kief, M. D., Fond du Lac

REPORT OF THE COMMITTEE ON INDUSTRIAL HEALTH

Your Committee was privileged to co-sponsor the American Medical Association's Congress on Industrial Health held in Milwaukee, January 26–29, 1958. Nearly 500 physicians and nurses throughout the nation attended the Conference. While the Conference certainly may be termed a success, it is the conclusion of the Committee that more wide-spread publicity among the physicians of the states neighboring the Conference might, in the future, produce substantial participation from the part-time industrial health physician who makes up so large a portion of this area of medical practice.

This Committee is pleased to report that the "Health News" bulletin on which this report is written is receiving widespread distribution among the businesses and industries of Wisconsin. A recent survey of the usage of this bulletin indicates that more than 350 industrial health nurses and industrial health departments use these reports as a basis for health educational articles on industrial plant bulletin boards and house organs. Survey replies indicated a genuine appreciation of the service and substantial encouragement for its continuation.

The Committee looks forward during the coming year to a cooperative effort with the Division on Visual and Hearing Defects of the Society's Commission on State Departments in a survey of industrial eye problems and the preparation of recommendations similar to those previously developed in the hearing field.

The third revision of "Occupational Health—A Guide for Physicians and Nurses in Industry" is enjoying wide-spread popularity among physicians and industrial nurses in the state. The Committee recommends that Society members throughout the state increase their familiarity with its recommendations for proper handling of full or part-time medical direction in small industrial plants in Wisconsin.

Respectfully submitted,

E. L. Belknap, M.D., *Chairman*, Milwaukee
D. E. Dorchester, M.D., Sturgeon Bay
T. S. Burdon, M.D., Green Bay
J. V. Flannery, M.D., Wausau
G. W. Petersen, M.D., Neenah
D. M. Ruch, M.D., Milwaukee
J. M. Wilkie, M.D., Madison
R. S. Wright, M.D., Racine

REPORT OF THE COMMITTEE ON CIVIL DEFENSE

Since outer space has become the playground of Sputniks and Explorers, it is at least reassuring to know that Civil Defense in Wisconsin is rapidly becoming well-established in an orbit of its own. After ten years of experimentation, trial and error, the Wisconsin Civil Defense Program is finally reaching the stage where terminology, responsibilities, and organization appear to be pretty well defined.

The State Office of Civil Defense recently announced completion of the State Survival Plan, including a program for health services. Your Committee has contributed to the development of this Survival Plan from its years of experience in planning at a time when few others were interested.

The new State Survival Plan describes the function, organization, planning responsibilities, control and communication of health, medical, and radiological services. Responsibilities are outlined for casualty care, provision of medical supplies and equipment, and public health and establishes outlines for hospitals, blood procurement, radiologic services, county medical services, and services in target areas and support regions. The duties of each of these sections are well outlined for a state of normal readiness, strategic alert, air raid warn-

ing, and postattack. Special attention is given to supplies, transportation, communication, and control.

The Committee is unanimous in agreeing that it is the most helpful description of responsibilities in communications yet prepared for Wisconsin Civil Defense Program from the health standpoint. It will be extremely helpful to all county medical societies' civil defense committees, mobile medical team captains, and county medical society directors.

The Committee has participated in activities of a special blood committee advising Doctor Neupert, State Health Officer and Co-Director of Health Services for Civil Defense. The result has been an excellent program for recruiting, organizing, and training emergency blood collecting centers in every county in Wisconsin which has a population of 20,000 or over.

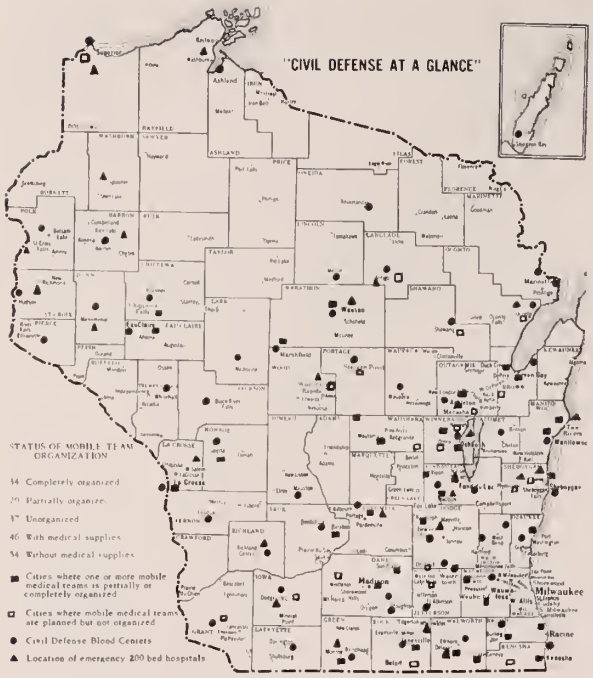
One of the most heartening aspects of Civil Defense in recent years is the sudden spurt of interest being shown by hospitals and county medical societies throughout the state in the development of local programs to handle natural disasters. While these are being established for the day-to-day prob-

WISCONSIN RADIO STATIONS CARRYING THE MARCH OF MEDICINE RADIO PROGRAM

April 1, 1958

Station	*City*	*Day*	*Time*
WATK	Antigo	Saturday	8:45 a.m.
WATW	Ashland	Saturday	4:45 p.m.
WGEZ	Beloit	Saturday	10:45 a.m.
WCHF	Chippewa Falls	Saturday	12:45 p.m.
WBIZ	Eau Claire	Sunday	7:00 p.m.
WEAU	Eau Claire	Saturday	11:45 a.m.
KFIZ	Fond du Lac	Thursday	7:15 p.m.
WTKM	Hartford	Friday	2:00 p.m.
WHSM	Hayward	Saturday	8:05 a.m.
WBAY	Green Bay	Saturday	5:15 p.m.
WCLO	Janesville	Tuesday	8:15 p.m.
WLIP	Kenosha	Saturday	9:05 a.m.
WKBH	La Crosse	Saturday	10:45 a.m.
WLDY	Ladysmith	Saturday	9:00 a.m.
WHA	Madison	Friday	10:30 a.m.
WIBA	Madison	Saturday	11:15 a.m.
WOMT	Manitowoc	Saturday	9:15 a.m.
WMAM	Marinette	Saturday	8:15 a.m.
WDLB	Marshfield	Saturday	9:45 a.m.
WIGM	Medford	Saturday	10:00 a.m.
WEKZ	Monroe	Saturday	1:45 p.m.
WCCN	Neillsville	Saturday	9:30 a.m.
WPFP	Park Falls	Saturday	10:45 a.m.
WSWW	Platteville	Saturday	9:05 a.m.
WPDR	Portage	Thursday	10:15 a.m.
WIBU	Poynette	Thursday	2:30 p.m.
WPRE	Prairie du Chien	Saturday	10:15 a.m.
WRJN	Racine	Sunday	6:30 p.m.
WRDB	Reedsburg	Saturday	12:45 p.m.
WOBT	Rhinelander	Saturday	10:15 a.m.
WJMC	Rice Lake	Saturday	9:45 a.m.
WRCO	Richland Center	Saturday	5:15 p.m.
WCWC	Ripon	Saturday	9:15 a.m.
WTCH	Shawano	Sunday	6:45 p.m.
WDOR	Sturgeon Bay	Thursday	10:45 a.m.
WTRW	Two Rivers	Saturday	9:45 a.m.
WTTN	Watertown	Tuesday	11:30 a.m.
WSAU	Wausau	Saturday	5:15 p.m.
WBKV	West Bend	Saturday	11:15 a.m.

Robert C. Parkin, M.D., Medical Director of March of Medicine.



WISCONSIN

lems of fires, explosions, accidents, floods, and tornadoes, they could well prove to be the backbone of the state's entire Civil Defense Program in the event of a military disaster.

The Committee stands ready to assist county medical societies and medical staffs in developing either natural disaster or civil defense plans.

Respectfully submitted,

E. P. Ludwig, M.D., *Chairman*, Wausau
J. S. Wier, M.D., Fond du Lac
E. A. Bachhuber, M.D., Milwaukee
S. J. Graiewski, M.D., Oshkosh
D. L. Williams, M.D., Madison
Harold Cook, M.D., Milwaukee

Mr. Louis Remily, State Board of Health, Madison

REPORT OF THE COMMISSION ON STATE DEPARTMENTS

The frequency and complexity of relationships between physicians and agencies of local, state, and federal government have taken a notable increase in 1957–58. This is most certainly not a temporary situation, but one which needs to be cultivated and improved if physicians, in the public interest, are to assure the people of sound medical programs whether under private or public auspices.

Each of the ten divisions of the Commission on State Departments has its own special sphere of influence and activity with state and federal health programs. Many overlap and others require close coordination. The Commission believes that this mechanism of relationships with governmental programs in the health field produces a more stable approach to health problems to the benefit of thousands of persons affected by these programs. At the same time the professional status and functions of physicians engaged in, or affected by, these programs are safeguarded.

The Commission urges your careful consideration of the reports of its divisions, for the implications of these programs to private practice and public health are substantial.

Respectfully submitted,

T. W. Tormey, Jr., M.D., *Chairman*, Madison
H. A. Anderson, M.D., Stevens Point
G. S. Kilkenny, M.D., Milwaukee
Maxine Bennett, M.D., Madison
Robert Boyle, M.D., Milwaukee
A. M. Hutter, M.D., Fond du Lac
L. M. Simonson, M.D., Sheboygan
H. W. Carey, M.D., Lancaster
H. A. Sincock, M.D., Superior
E. D. Schwade, M.D., Milwaukee
R. S. Gearhart, M.D., Madison

REPORT OF THE DIVISION ON SCHOOL HEALTH

Proper handling of the health problems which affect school students, teachers, and administrators depends in large measure upon the effort exerted in this direction by the county medical society.

With that in mind, the Division on School Health recommends that each county medical society establish a continuing committee on school health consisting of at least three members. The purpose of this county medical society committee is primarily an annual discussion of school health problems with superintendents of schools, high school principals, local health departments, representatives of the dental society, Parent Teachers Association, and other groups.

Guidance for such committees is available through the Division on School Health by literature and other material. Such a committee could accomplish many things, but if it did no more than meet annually with non-medical people who are charged with looking after the needs of children while they are in school, the county committees will have made a great contribution to better health in Wisconsin.

County medical societies are urged to adopt an active school health program. In doing so they may wish to be acquainted with other actions of your Division which have importance to the total school health picture:

1. A review of the iodine tablet program in Wisconsin produces no evidence to indicate a change in the State Medical Society's previously announced policy. It continues to emphasize the necessity for the use of iodine tablets for all young people through age 21 and urges a special effort with nutritionists and physicians throughout the state to encourage the use of tablets through high school ages.

2. A day long Institute on Athletic Injuries will be held in Milwaukee, November 7, 1958. This will be a conference for physicians and coaches on problems of injury and stress among growing youth. Among the topics will be discussion of cardiology, neurology, contusions—lacerations—inflammations, knee and ankle injuries, growth development in fatigue, taping and physical therapy. This program will be presented through the State Medical Society's Charitable, Educational and Scientific Foundation under direction of the Division on School Health and in cooperation with the Wisconsin Interscholastic Athletic Association.
3. The Division is participating in an effort of the Wisconsin State School Health Council to prepare specific literature for the guidance of school personnel in the handling of health emergencies in the school.
4. The Division recommends that physicians emphasize physical fitness in its broad aspects, especially in interscholastic athletic competition and school recreational activities.
5. The Division has worked with the Wisconsin Congress of Parents and Teachers in the use of traditional health record form for preschool and periodic physical examinations. As a result, the Parent-Teachers Association will abandon its own form which was at variance in many respects to the approved pattern established by recognized state health agencies.
6. The Division has recommended to the Wisconsin Interscholastic Athletic Association Board of Directors that it eliminate requirements that any medical attention automatically drop an athlete out of competition for five days. In many cases students with minor injuries hide their ailments rather than subject themselves to the five-day penalty. The non-competition requirement is suggested, however, as reasonable for aspirations and cuts. In addition, a number of other medical regulations are under study by the Division with the Wisconsin Interscholastic Athletic Association officials with a view to improving their effectiveness.

Wisconsin physicians are invited to attend the Division's exhibit entitled, "Health Appraisal of the School Child," at the Annual Meeting. The same exhibit will be shown at the Wisconsin Education Association convention in the fall of 1958.

Respectfully submitted,

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William A. Nielsen, M.D., West Bend
K. J. Winters, M.D., Wauwatosa
John G. Heisel, M.D., Superior
E. E. Bertolaet, M.D., Kenosha
Amy Louise Hunter, M.D., State Board of Health, Madison

Mr. Orlo Miller, State Department of Public Instruction, Madison
Mrs. Dorothy Barnett, State Board of Vocational and Adult Education, Madison
Mr. Robert Cade, State Board of Health, Madison

Subcommittee on WIAA: L. M. Simonson, M.D., Sheboygan, Chairman; D. W. McCormick, M.D., Fond du Lac; W. R. Manz, M.D., Eau Claire; D. G. MacMillan, M.D., Rice Lake

REPORT OF THE DIVISION ON PUBLIC ASSISTANCE

Wisconsin, far ahead of many other states with liberal public assistance laws, has discovered that a federal act passed almost two years ago may change the face of medical care programs for public assistance recipients.

The reasons are relatively simple:

With the true charity patient the physician carries out his traditional obligation to provide his services at no cost, or at most, a very reduced fee. With the state and county, through their public assistance programs, the physicians generally accepted reduced fees in return for the assurance of direct and full payment of their reduced bill.

In mid-1957, however, by federal social security amendment, many states like Wisconsin found themselves unable to continue the direct payment of physicians' reduced fee schedules if they wished to qualify for federal aid. To obtain the federal money the state welfare department was obligated to set up payment programs by which the assistance went directly to the recipient who in turn paid the physician. Many physicians have felt that the "strings" to federal government aid have the effect of placing them in the same category as the grocer, fuel dealer and clothing merchant whose bills to governmental agencies are calculated on the "going rate" and whose payment is neither expected nor given on a reduced basis. What this may do to public assistance fee schedules is uncertain.

The new procedure, in effect since July 1, 1957, made it necessary for state and county welfare departments to comply with the federal regulation as a means of obtaining the maximum amount of federal funds available for supporting public assistance programs. In Wisconsin's case the choice of the recipient payment method meant that the state received about $2,000,000 in federal aid that it had not obtained earlier.

The effect of the change was greater in some counties than others. Some had already used recipient payments for many years. For others who had used largely vendor payments, the change was more drastic.

While the physician must usually look to the patient for payment of all medical services, it should be pointed out that county welfare agencies are permitted to pay the physician directly when the recipient dies, when he has demonstrated unreliability or is known to be a poor payment risk, or when the recipient voluntarily requests that payment be made directly to the doctor because of invalidism or residence a long way from the doctor's office.

Why the federal government will not make its matching aid available equally for payments to doctors or to the recipient is not clear. There is every indication that the policy is based upon a long-time political fundamental in government affairs—that federal public assistance aids be used in such a way as to place the cash directly in the hands of the recipient.

Your Division has agreed to watch the operation of the new payment system closely and it urges physicians to report their experience with the recipient payment plan so that the Society's views can be adequately represented to the state and county welfare officials.

Respectfully submitted,
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Mr. T. J. Lucas, Sr., State Department of Public Welfare, Madison

REPORT OF THE DIVISION ON SAFE TRANSPORTATION

Last year there were more than 26,642 personal injuries, plus 919 deaths, as a result of vehicular crashes in Wisconsin. There were about 220,000 accidents of all types in the state in 1957 with nearly 50% involving injuries of serious consequence.

Faced with this record the Division on Safe Transportation delved deeply into driver licensing laws in Wisconsin, high school driver training programs, regulations for school bus drivers, treatment of crash injuries, ambulance operation, medical society participation in traffic safety councils and driver license examination.

These studies have led the Division to the following recommendations which have been approved by the Commission on State Departments and placed before the Council of the Society:

1. Driver education courses, including both classroom and behind-the-wheel instruction of suitable caliber, are recommended for all Wisconsin high schools.
2. All school driver education programs should require the installation of safety belts in driver education cars.
3. The Society's Committee on Public Policy should give consideration to legislation prohibiting the issuance of a driver's license to any person prior to age 18 unless, between ages of 16 and 18, he has passed an approved driver training course including both classroom and behind-the-wheel instruction.
4. All police and sheriff department members, ambulance drivers and firemen should be trained in first aid, preferably by an organized program conducted by the county medical societies as a public service or through Red Cross. Physicians are urged to assume responsibility for actual training.
5. Concerned that many ambulances are operated in such a way as to create a public hazard, ambulance services, whether public or private, are urged to observe all traffic laws when transferring patients to hospitals. Ambulances and their police escorts should drive at speed within the state law under all circumstances.

During the year this Division has carried on a public educational effort aimed at developing in every driver a "crash reaction habit" to prevent death and unnecessary suffering as a result of automobile accidents. The "crash reaction habit" should include immediate inspection of the persons involved in an accident to determine the extent of injury, applying necessary first aid, and notifying the police. Seldom is it necessary, the Division believes, to have a physician at the scene of an accident. It is more important to transport the accident victims properly and promptly to the nearest hospital.

The Division believes that the public should learn that the application of first aid can be just as important as learning to drive safely. Through news releases and radio announcements, the Division called attention to the fact that all official Wisconsin state highway maps carried first aid instructions and a list of the cities which have general hospitals. Drivers were urged to become familiar with these instructions as a lifesaving precaution. Two "March of Medicine" programs were presented this year with Division members as participants.

Believing that the application of sound health principles is vital to proper safety education and training, the Division is cooperating with a number of governmental and private groups interested in safety. It is, of course, working closely with the Motor Vehicle Department in the health aspects of its affairs. It is following closely the activities of the governor's special coordinating committee on highway safety of which Dr. C. N. Neupert, State Health Officer, is a member. It has representation on the Motor Vehicle Administration Commission of the Wisconsin Council of Safety and has a member on the Advisory Board of the University of Wisconsin Research and Safety Education program. Similarly, one of its members serves on the Home Safety Committee of the Wisconsin Council of Safety.

A series of important study projects are under way. The first of these is a thorough review of the health aspects of the driver examiners manual used by the force of 100 official driver licensing examiners throughout the state. The second is a review of all laws concerning the licensing of school bus drivers with special emphasis on the physical examination, vision, hearing, use of limbs, and freedom from communicable disease. The third is a cooperative study with the Division on Visual and Hearing Defects on requirements for driver licensing.

Respectfully submitted,

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Dayton Hinke, M.D., Richland Center
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Mr. John W. Thompson, Motor Vehicle Department, Madison

REPORT OF THE DIVISION ON GERIATRICS

A few quick facts will focus attention on one of the major problems in geriatrics today:

> Wisconsin has 882 homes providing nursing care for the chronically ill. 70% of these are proprietary, 20% are non-profit organizations, and 10% are governmental institutions.
>
> A total of 18,129 patients or residents live in these homes. More than 6,800 (38%) of these resided in proprietary homes. More than 5,500 (30%) resided in non-profit organizations and a total of 5,700 (32%) were housed in governmental institutions.

The Division on Geriatrics has directed much of its effort of the past year toward helping county medical societies take a more direct role in the establishment of adequate nursing home facilities, in offering guidance and assistance in the planning of new nursing home facilities and the improvement of already established homes, and in offering advice for the improvement of patient care in nursing homes.

In mid-1957 every county medical society received a packet of informational materials dealing with the establishment of an adequate facility for nursing home care. This packet was compiled by the Division in cooperation with the State Board of Health, the Division on Public Assistance of the State Department of Public Welfare, and the Agency for the Chronically Ill of Milwaukee. These materials set forth the laws of the state and some common sense guides for the establishment of nursing home facilities, including such things as location, management, operation, admittance procedures, health care, and the like.

As a related matter the Division once again directs the attention of physicians to the Society's guide entitled "Minimum Standards of Medical Care for County Hospitals." While this was prepared some years ago, it is still an excellent aid to physicians and county asylum superintendents concerning medical care for patients in county hospitals. It is available from the Society upon request and without cost.

The Division expresses concern about one aspect of life in Wisconsin nursing homes: many patients in such homes do not have a listed physician. Patients who are receiving public assistance are usually seen regularly by a physician whereas private patients are often seen by a physician only when a nursing home operator calls and this is most likely in case of illness or injury. There is seldom a periodic checkup for the private patient in nursing homes. The Division proposes to continue exploration of this problem with the State Board of Health to assure that nursing home regulations require each patient to select a physician for regular or emergency care. In addition, the Division believes it highly desirable, as a matter of good nursing policy, to assure periodic visits by the physician for all bedfast patients.

The Division is watching closely the pilot project of the State Board of Health in the restoration of the bedridden aged to some degree of self-care. This project is being undertaken in Brown County and the Division expects periodic progress reports from the Board of Health as a matter of public information.

The Division is representing the State Medical Society of Wisconsin in planning the Second Governor's Conference on an Aging Population which is scheduled for June 4–5, 1958. At the close of the Governor's Conference there will be a one-day workshop conference for physicians and nursing home operators as a means of directing specific attention to problems in this field. Physicians interested in geriatric problems are urged to attend the Governor's Conference and the nursing home workshop.

Respectfully submitted,

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REPORT OF THE DIVISION ON VISUAL AND HEARING DEFECTS

Visual and hearing requirements for school bus drivers have recently been reviewed by the Motor Vehicle Department. In response to a request from the Department, the Division on Visual and Hearing Defects has made the following recommendations:

1. Recommended hearing standards for the licensing of school bus operators:

   A. All applicants for a license shall have a pure tone air conduction threshold audiometric examination.

   B. An acceptable result should be one that will show the average hearing loss in the better ear in the three speech frequencies (500 cps, 1000 cps and 2000 cps) to be no greater than 30 d.b. (Any greater loss indicates that the operator will have great difficulty in hearing conversation of the passengers of his vehicle, an important factor in safety of school bus operation. Operators with hearing aids are not acceptable because they have difficulty hearing sounds over and above motor and road noises.)

   C. The above audiometric examination is to be made by competent examiners. (Every county public health nurse's office has at least one audiometer and the nurse is trained in its use.)

   D. If there is question of the validity of an audiometric examination as it relates to the ability of an applicant to meet the requirements, he should be referred to an otologist for further evaluation and report to the Motor Vehicle Department.

   E. In examining the applicant, an attempt should be made to elicit a history of vertigo or Meniere's Disease, and if shown, the applicant should seek the opinion of an otologist as to ability to safely operate a bus.

   F. Each school bus operator should have his hearing reevaluated a minimum of once every three years.

2. Visual requirements for the licensing of school bus operators:

   A. A minimum best correctable visual acuity of 20/40 in each eye.

   B. A minimum horizontal form field of 70 degrees in each eye. (It is recommended that the field examination be included in the test given school bus drivers, and that examiners be instructed in the method of gross field testing.)

   C. Color perception should be tested and when weakness reveals itself, the applicant should be informed and cautioned to be unusually observant in this regard.

In making these recommendations, the Division wishes to emphasize the difference between operation of private vehicles and operation of passenger transportation vehicles such as school buses. For example, hearing loss or deafness does not ordinarily reduce the driving ability of a vehicle operator. However, a school bus operator with hearing loss presents clear safety hazards to his inability to respond to conversation or other activities of his passengers. Similarly, the visual acuity of the school bus operator is of greater public concern in light of the responsibility he has for many lives.

The Division also reviewed in detail the Wisconsin Hearing Conservation Program operated under the direction of the Bureau for Handicapped Children of the State Department of Public Instruction. This program was active in 26 counties and 15 cities during 1956–57. An estimated 150,000 children were audiometrically tested in this program. More than 1,500 volunteers were trained in the use of the pure tone audiometer for sweep testing. A total of 5,700 children were audiometrically rechecked by the two hearing consultants of the Bureau. As a net result, nearly 1,700 children whose audiometric tests revealed hearing loss were examined at 58 otological clinics. The Division extends its commendation and appreciation to the 23 otologists who conducted these clinics.

Approximately one-third of the counties of the state are included in the Hearing Conservation Program each year. The Division believes that the Bureau for Handicapped Children is operating a most outstanding and effective program for the detection of hearing loss, and it extends its commendation for conducting its program according to the highest principles of otologic care.

At least four other matters have been of major concern to the Division in the past year:

A. Physicians are urged to give special attention to the possibility of hearing losses resulting from the use of certain antibiotic drugs, particularly streptomycin and neomycin. There is evidence that even relatively few injections of these drugs are capable of producing permanent hearing losses in susceptible individuals. The indiscriminate and prophylactic use of these particular drugs should therefore be avoided.

B. A study is to be undertaken of current industrial practices in pre-employment audiometric testing and interpretation. Reports from various parts of the state indicate that in some industrial programs interpretation of the audiograms is being undertaken by unqualified persons. The Division believes that the interpretation of the audiogram is a medical function which should preferably be per-

formed by the physician or at least should be under medical supervision.

C. The Division is also studying the effect of federal laws under which the State Department of Public Welfare is required, as a condition of receiving federal financial support, to accept reports of optometrists as "medical evidence in support of a determination of blindness."

D. A cooperative study with the Committee on Industrial Health is to be developed as a means of preparing a guide for industrial vision programs. In some areas safety goggles have come to be regarded as a fringe benefit to be negotiated. This leads to attempts to have the goggles serve both a plant safety and a personal general purpose function. A variety of "standards" for safety goggle programs are being distributed and specifications for goggles are being established by individuals without professional or technical training in the field.

Now, in a broader sense, the public interest urgently demands a reassertion of sound eye care principles by the medical profession. The public must not mistake limited license, civic participation and self laudation for professional competence.

The eyes are an integral part of the human body. Their ability to function properly is related to innumerable factors of health and disease as well as to light and the laws of physics. Adequate care of the eyes and the conservation of sight is as clearly a medical problem as proper care of the ear and the conservation of hearing.

The mechanical testing of visual acuity is but one measurement of the ability to see. It may establish a visual defect; it does not necessarily indicate the cause. The mere fitting of a lens is certainly not a diagnosis, nor is it necessarily a proper treatment. It is possible at times to diagnose ocular disease without the use of drugs, but it is not possible to diagnose the *absence* of disease without the use of anesthetics for glaucoma and mydriatics for other diseases. Drugs cannot be used safely unless there is knowledge of how to treat pathologic conditions which may occur in the course of their use. Tests for diagnosis of disease may be therapeutic tests and some may have to be performed on other tissues. Thus, it is completely apparent that proper care of the eyes must be a part of the practice of medicine and surgery. The public must understand this if it is to know that there is no adequate substitute for medical eye care in the preservation of sight and the detection and treatment of eye defects.

In school systems, industry, Workmen's Compensation, public assistance, driver licensing, and even in the legislature, these fundamentals of good health tend to be forgotten and overlooked, or possibly ignored under the misleading influence of nonprofessionals in the field.

The medical profession has long since learned, and the lesson is being re-taught today, that it cannot compromise the public well-being on any health sound eye care are well-known to every physician. issue. Eye care is no different. The principles of Attempts to negotiate them by legislation involving ancillary personnel have been notoriously unsuccessful. Medicine must reassert these principles to the public and to the legislature for both look to it for guidance and expert advice just as surely as they seek the counsel of the practicing physician for personal health matters.

Respectfully submitted,

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REPORT OF THE DIVISION ON HANDICAPPED CHILDREN

The orthopedic clinic program in Wisconsin has long been characterized as one of unusual cooperation between medical practitioners and the official state agency charged with allocation of federal funds for this purpose—the Bureau of Handicapped Children. The Bureau, through its medical advisors, has made regular use of State Medical Society and Orthopedic Society advice. No clinics are conducted without the direct request and approval of the county medical society in which the clinic is held.

While the program has accomplished much and has been acceptable to the medical profession, changes are obviously in order. The incidence of polio is less and the number of qualified orthopedic surgeons in the state has increased at the same time their geographic distribution has improved.

Therefore, it is the recommendation of the Division, approved by the Commission on State Departments, that in areas where two or more qualified orthopedists are in practice that clinics be discontinued if such is the desire of the county medical society and if in the opinion of the Bureau and the orthopedists in the area, both old and new patients can and will be adequately served on a direct referral basis.

All physicians whose patients have heretofore attended clinics are asked to give consideration to this matter and if the discontinuation of clinics in the area is suggested, to make their wishes known through their county medical society which must approve the clinic before it is held.

The Bicillin Program, conducted by the Bureau in cooperation with the Wisconsin Heart Association,

provides a mechanism for making bicillin available to patients at a reduced rate upon the request of the family physician. This program has been reviewed and approved with the following modifications:

1. When a family physician indicates the possibility of rheumatic fever and the evaluation clinic of the Heart Association will not provide confirmation for several months, it is recommended that a supply of bicillin be sent the physician until such time as the required confirmation is obtained. After confirmation the family physician should indicate whether or not the drug will be purchased by the patient or through the Bureau for continued therapy.
2. In cases where a patient fails to reorder bicillin and the report of the patient suggests long-term therapy, it is requested that the family physician be notified and asked to make contact with the patient so that continued therapy will be assured.

Although only 250 patients were served by the program last year, the bicillin program is an important supportive part of the therapy for patients having rheumatic fever.

Two related services to handicapped children identified with the University of Wisconsin Medical School were reviewed by the Division during the year. One of these is the amputee program of the University through which physicians facing the problem of children born without extremities may obtain services through a special clinic. In cases where financial assistance is indicated, the Bureau of Handicapped Children is prepared to provide funds for the manufacture of the prescribed prosthesis. A similar service is available in Milwaukee at Columbia Hospital. While the facilities of these clinics are somewhat limited, all physicians whose patients indicate a need for this service are urged to inquire as to help which might be given.

In the area of muscular dystrophy there is a service of combined research and diagnosis being conducted at the University of Wisconsin Medical School. It is being coordinated with the fields of neurology, genetics and other facets of research associated with the disease. The service is one of consultation to the family physician and his patient through evaluation and prescribed therapy. There is no cost to the patient except transportation to and from Madison. Physicians are urged to contact the University of Wisconsin if they wish to utilize the services of this study.

The Division is concerned with the trend in some voluntary health agencies to develop medical programs without immediate direction of organized medical groups. This has been particularly true of the cerebral palsy programs in the state. The Division urges that county medical societies take an active role in the medical aspects of such programs.

Recommendations

1. If or when recommendations are made for the discontinuation of orthopedic clinics in areas where such service is available on a private basis, the county medical society in the area in which the clinic has been held is urged to carefully study the problem. Cooperation with the Bureau of Handicapped Children is suggested and every effort should be made to assure that discontinuation of the program will in no way neglect the needed care of patients normally served by the clinic.
2. Physicians who have patients with rheumatic heart disease are urged to acquaint themselves with the bicillin program of the Wisconsin Heart Association and the Bureau of Handicapped Children. Patients requiring long-term therapy and whose continued care may work a financial hardship on the family, may be certified to the Bureau for participation in the program.
3. Physicians are urged to cooperate with the University of Wisconsin Medical School in the program of research on muscular dystrophy by encouraging patients to make themselves available for the study. In cases where transportation to Madison is not practical, physicians are urged to provide the required history and laboratory specimens so that the research project can be made as complete as possible.
4. Physicians are urged to take an active role in medical aspects of voluntary health programs on a county level. County medical societies should exercise an active role in the determination of medical programs conducted by voluntary health agencies.

Respectfully submitted,

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REPORT OF THE DIVISION ON REHABILITATION

Almost a year has elapsed since the federal government began providing monthly social security disability payments to disabled workers 50 years of age or older and to certain disabled children. The first payments began in July, 1957, and by the end of November, 1957, more than 2,620 eligible persons in Wisconsin (140,504 in U. S.) were receiving benefits because they have been determined to be so completely helpless that they were unable to "engage in any substantial gainful activity."

The average benefit paid under the disability program is $72.47 per month. This is only part of the picture. Since the program was announced, through October, 1957, more than 18,000 persons in Wisconsin (1,071,482 in the U. S.) have applied for either disability benefits or disability freeze. Even now the Rehabilitation Division of the State Board of Vocational Adult Education which administers the disability evaluation program in Wisconsin is receiving about 500 applications per month.

It is these applications which have concerned the doctor and the Society's Division on Rehabilitation during the past year in particular. Each applicant, if he has sufficient social security credits, is responsible for obtaining the medical evidence needed to show the extent of his disability. When he makes application, his local social security office provides him with the medical report form on which medical evidence can be supplied by the applicant's physician. Physicians should understand that each applicant is given a pamphlet and is told that physicians furnishing medical examinations and reports "are not asked to decide whether you are or are not 'disabled' under the Social Security Law." This is to relieve what might otherwise be undue pressure on the physician.

Under no circumstances does the physician determine disability even on a consultative basis.

On the medical report form or by way of a narrative report the physician is asked to provide a medical history, the results of his examination and treatment, the severity of the illness or injury, the results of the clinical tests and the nature of treatments provided. Most important of all is the necessity for the physician to understand that he is to provide only clinical, medical evidence—facts upon which the state agency can make the determination of disability. Your Division has worked closely with the State Rehabilitation Office to simplify the reporting procedures and to create better understanding among the physicians as to what is desired on the report forms.

Consultative examinations have been a problem of special importance and the Division has been of assistance in this area. Routinely when a consultative examination is needed, the State Rehabilitation Office selects a physician from among those known to be specializing in a particular field or who have indicated their willingness to provide the information requested. Referrals are made to board and nonboard specialists and in some cases to general practitioners. In instances in which the reporting physician wishes to refer directly to the consulting physician, arrangements can be made on request to have this done.

The State Rehabilitation Division has been invited to call or write the State Medical Society office whenever it feels that further information and advice is needed from physicians and when such advice has been difficult to obtain. A similar relationship has existed with the Industrial Commission for years and has worked in a most satisfactory manner.

Continuing publicity will be given in the *Wisconsin Medical Journal* to the problem of disability evaluation so that physicians might have a greater understanding of the information desired and the simplest methods of assisting in the evaluation process.

In other activities your Division has studied the application of minimum wage laws to sheltered workshops and has expressed the opinion that totally non-profit sheltered workshops or rehabilitation centers which engage in such activities primarily for the purpose of providing physical and mental rehabilitation in the medical sense should be exempt from minimum wage laws if they are to survive as an adjunct to professional rehabilitation care.

The Division urges all physicians to visit the exhibit on rehabilitation at the Auditorium during the Annual Meeting.

Respectfully submitted,

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REPORT OF THE DIVISION ON CHEST DISEASES

A new name and a new emphasis has been brought to this Division of the Commission on State Departments. Formerly known as the Division on Tuberculosis and Chest Diseases, this Division has been reconstituted to broaden the scope of its activities by including physicians whose primary interest is that of cardiology. This change in emphasis reflects an important and significant change in the area of pulmonary disease. As a result, the work of the Division in the future will be broadened to cover tuberculosis and related diseases of the chest, in particular, heart and carcinoma of the lungs.

Mass Screening for Tuberculosis

The decreased case load of patients in county and state sanitoria has created the illusion that tuberculosis is a "conquered disease" and that mass screening is no longer necessary. Quite the contrary is true. The operation of mobile chest x-ray units in Wisconsin provides unquestionable information that mass screening is still the most effective manner in

which the extent of tuberculosis can be determined and practical measures taken to bring it under control. Moreover, the operation of these units has not only been an important factor in ferreting out cases of tuberculosis which might have otherwise been overlooked, but they have likewise revealed hundreds of cases of heart disease or suspected cancer which are of significant importance in the overall health program in Wisconsin. There is great need for an intensified program of detection within age groups where tuberculosis is most prevalent. Patients in nursing homes, in mental institutions and children over 15 years of age all present special problems in tuberculosis which suggest need for an intensified screening program of these groups. Skin testing techniques can be used more effectively and with less cost among school children. Thus, it is recommended that this type of program be carried on with regularity in all Wisconsin schools, both public and parochial.

Radiation Hazards

A great deal of misinformation has been written and quoted in relation to radiation hazards of mass screening programs. Aware of this, the Division on Chest Diseases published in the March, 1958, issue of the *Wisconsin Medical Journal* a concise factual statement which should be read by every physician. The hazards of radiation exposure in routine x-rays are negligible if proper protective techniques are employed. It is essential that both the profession and the public be informed as to the true and misleading aspects of this topic so frequently discussed in non-medical publications.

Health Examinations of School Employees

The State Medical Society took an active role in the enactment of legislation a decade ago which permitted school boards to use public funds for the examinations of school teachers and other personnel, particularly in reference to chest examinations for tuberculosis. In the last session of the legislature the State Medical Society again took the leadership in changing this permissive legislation to make such examinations mandatory. It is important that local physicians assist school boards in carrying out this program in a manner that is efficient, fair and reasonable.

Physician Responsibilities

With the use of new drugs and increased ambulatory care of the patient with tuberculosis, the family physician has an added responsibility to make certain that prescribed therapy is followed. It is still important that patients be encouraged to subscribe to institutional care at least during the initial phase of their recovery. The Division is of the opinion that, generally speaking, institutional care in the initial stages of treatment is still the best approach to the most effective care of the patient. It is recognized that physicians are under considerable pressure on the part of patients to institute ambulatory care. However, such an approach too often leads to lapses in therapy with resulting breakdowns often to a point where ultimate institutional care presents problems of severity which might have been avoided had the patient been originally institutionalized.

The physician is in a position to determine which of his patients has the strength of character to carry on a daily treatment program over a course of many months or years. He, too, must determine for himself to what extent he is willing to assume the professional supervision which is required for long-term daily care.

Recommendations

1. All physicians are urged to carefully evaluate their patients with tuberculosis to determine the extent that ambulatory care is practicable and workable in terms of self-discipline of the patient and the physicians' own responsibilities to provide unusual supervision and evaluation on a long-term basis.
2. All physicians are urged to support the efforts of the State Board of Health and local health units in operation of mobile x-ray units as a means of detecting unsuspected tuberculosis and revealing important chest abnormalities not related to tuberculosis.
3. Physicians are urged to support and recommend a complete and annual skin testing program among children of school age.
4. Physicians in county societies are urged to assist local school boards in enacting effective regulations to implement the new state law requiring periodic health examinations of teachers and school personnel.
5. Physicians are urged to review their x-ray programs, techniques and equipment, in accordance with the *Wisconsin Medical Journal* article of March, 1958 to assure that radiation exposure is held to the minimum consistent with good medical practice.

Respectfully submitted,

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REPORT OF THE DIVISION ON MATERNAL AND CHILD WELFARE

The miracle of life is perhaps most dramatically illustrated in the period from conception to birth when attention is focused on both mother and child. It follows then that the scientific adventures in this critical period of human development take on great significance in the Society's program of professional and public service.

The dramatics of this early episode in life heighten the challenge for the physician and the State Medical Society. Even though Wisconsin's maternal and infant mortality records are excellent, the physician never ceases to hope that his efforts in combination with the patient might someday achieve perfection.

Maternal Mortality Survey

Through this Division, a Wisconsin maternal mortality survey is in its fifth year of study. Significant time, effort and cost have gone into the research and study phases of this program. At the same time emphasis has been placed on its educational aspects with the result that the Division has sponsored four teaching institutes to bring to the attention of Wisconsin physicians certain aspects of the study which have special bearing on maternal demise. Four programs in 1958 have been attended by 298 physicians, 19 medical students and 189 nurses.

It is heartening to receive many reports indicating that physicians are increasingly aware of the early signs of hypofibrinogenemia and other blood disorders. Significant too is the increasingly large percentage of maternal deaths in Wisconsin which are associated with causes other than those directly concerned with pregnancy. This indicates substantial results from postgraduate educational effort.

Prematurity Institutes

In the past year two institutes were held: one at Sacred Heart Hospital, Eau Claire, and the second at St. Mary's Hospital, Wausau. It is hoped that during the ensuing years similar teaching programs can be presented in selected areas in the eastern and northeastern parts of the state to emphasize the giant responsibility of physicians and hospital personnel in premature infant care.

Fetal Neonatal Study

This program, conducted on a pilot program basis two years ago and reported in detail to the House of Delegates, has been continued in Milwaukee County. It is being reported as a part of the program on obstetrics on Wednesday, May 7.

"Prenatal Facts"

This special form for obstetrical patients was created in 1956 for physicians to record significant facts and follow them in the hospital prior to the advent of the anticipated delivery. It is particularly helpful in the possible emergency care of the patient in the absence of the attending physician while he is reaching the hospital. The form has been adopted as routine in a number of Wisconsin hospitals and requests for copies are being received from all parts of the country. The initial supply of 5,000 copies has been exhausted and a revised form is being prepared for continued use.

Medical Problems for Migrant Workers

Maternal deaths among migrant workers in Wisconsin have been sufficiently frequent to suggest the need for an educational program to encourage better prenatal care and cooperation on the part of the pregnant worker. The problem is complex and often goes beyond the field of medical practice into such factors as language complications, traditions of midwifery, and sociological and environmental problems. A meeting has been held with the migrant workers committee of the Governor's Commission on Human Rights to explore possibilities of an educational program.

Use of Penicillin in the Prophylaxis of Neonatal Ophthalmia

With the advent of antibiotics, requests have been made on several occasions to permit the use of agents other than silver nitrate as a prophylactic in the prevention of neonatal ophthalmia. Although additional experience has been attained in the use of penicillin, the Division expresses the view that the safest procedure is to continue the use of silver nitrate. Since this is a matter of Wisconsin statute, the Division is cooperating with the Council of the State Medical Society in a renewed study of the matter in the hope that a satisfactory conclusion will be available prior to the 1959 session of the Wisconsin Legislature in the event that a change in the law seems indicated.

State Board of Health Regulations in Respect to Maternal Care

Current regulations of the State Board of Health in reference to isolation of patients on obstetrical floors and other procedures in relation to the care of the obstetrical patient in Wisconsin hospitals are being reviewed as part of a study of the entire administrative code of the State Board of Health. In the coming year it is anticipated that all regulations of a medical character will be reviewed and suitable recommendations made if modification of current regulations seems in order.

Trends in Obstetrics in Wisconsin

"How to prevent premature interruption of pregnancy" poses a problem on which attention must be focused if there is to be any real reduction in infant mortality in Wisconsin. Babies born prematurely—immature infants weighing 5 lbs. 8 oz. or less—account for over 75% of our neonatal and fetal

loss. Review of statistical data and careful case study by physicians and hospital staffs may point up ways to help expectant mothers carry their babies successfully to term.

Complications of pregnancy appear on birth certificates more frequently today than a decade ago—1 in 22 livebirths in 1946; 1 in 17 in 1956. Although there may be better reporting of pregnancy complications, some of the increase is accounted for by medical advances which have brought to light such problems as Rh incompatibility. Likewise, new knowledge, techniques and drugs have made it possible for doctors to better control such conditions as diabetes, rheumatic and congenital heart disease so that girls and young women with these conditions live longer, marry and have families. The increasing number of expectant mothers with diabetes and heart conditions presents a very real challenge to physicians providing prenatal supervision and delivery care. Another factor is that in attempting to clarify the frequency of premature deliveries more emphasis has been placed on the sequences following premature rupture of membranes. This item appeared as a complication in 678 deliveries in 1956. Tables 1, 2 and 3 have been prepared with the hope of focusing attention on changing problems which need further study. They may also be helpful in establishing trends with which future experience may be compared. More knowledge of factors responsible for the higher incidence of threatened abortion, placental complications and other hemorrhages prior to delivery may make it possible to save not only more mothers but to reduce fetal and neonatal loss.

In this era of larger families the need for careful review of all indications prior to Cesarean section, especially the first, needs re-emphasis. Surgical delivery creates additional hazards for the mother and child. In some instances a mother may have three, four or more Cesarean sections. With each the risk increases. A review of a fairly comparable number of recorded births for incidence of Cesarean section shows the changing picture.

	1934–1940 (7 years)	1941–1946 (6 years)	1953–1956 (4 years)
Deliveries	383,277*	382,420**	364,777**
Cesarean Sections	7,729	10,888	13,502
State Average	2.02%	2.85%	3.70%
County Distribution (71 Counties)			
0.0%	10	6	5
0.01–2%	54	36	12
2.01–4%	5	23	32
4.01–6%	2	6	15
6.01% and over			7

*Livebirths and fetal deaths.
**Livebirths only.

In order to show the very wide range of actual experience with Cesarean sections the two later periods are mapped by counties.

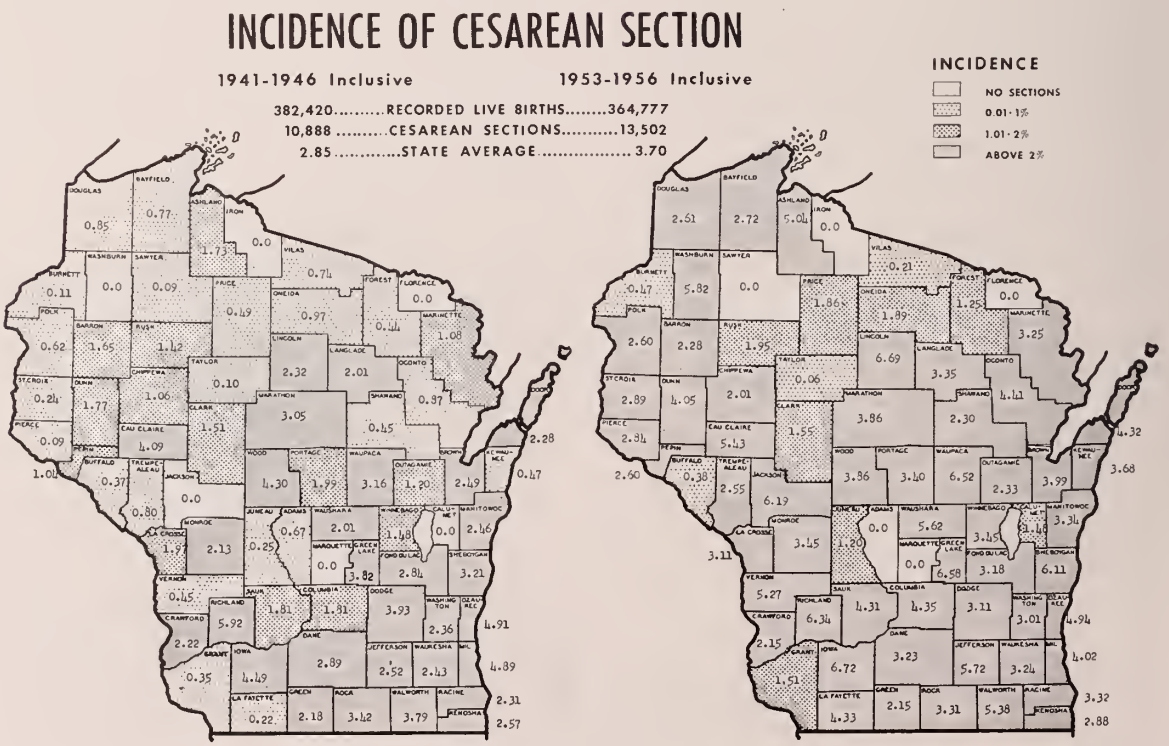

TABLE 1.—COMPLICATIONS OF PREGNANCY—RATE PER 1,000 LIVE BIRTHS—WISCONSIN RESIDENT DATA

	1946		1953*		1956	
Total Live Births	74,144		88,408		93,496	
Total with Pregancy Complications	3,436		4,479		5,514	
Rate per 1,000 Live Births	46.34		50.66		58.98	
Type of Complication	No.	Rate	No.	Rate	No.	Rate
Toxemia	1,298	17.51	1,444	16.33	1,435	15.35
Premature Rupture Membranes	------	------	410	4.63	678	7.25
Placenta Previa	191	2.58	286	3.24	402	4.30
Other Hemorrhage	249	3.36	316	3.57	484	5.18
Rh Factor	------	------	229	2.59	398	4.26
Anemia of Pregnancy	182	2.45	126	1.43	104	1.11
Pyelitis of Pregnancy	110	1.48	111	1.26	158	1.69
Disproportion—Abnormal Position	------	------	42	0.48	13	0.14
Other Obstet. Complications	339	4.57	660	7.46	613	6.55
Total Obstet. Complications	2,369	31.95	3,624	40.99	4,285	45.83
Other Complications	1,067	14.39	855	9.67	1,229	13.15
Total Complications	3,436	46.34	4,479	50.66	5,514	58.98

TABLE 2.—COMPLICATIONS OF PREGNANCY—PER CENT OF FETAL DEATHS—WISCONSIN RESIDENT DATA

	1946		1953*		1956	
Total Fetal Deaths	1,300		1,251		1,235	
Total with Pregnancy Complications	527		465		517	
Per cent of Fetal Deaths	40.54%		37.17%		41.86%	
Type of Complication	No.	%	No.	%	No.	%
Toxemia	168	12.93%	129	10.31%	117	9.48%
Premature Rupture Membranes	------	------	62	4.96%	35	2.84%
Placenta Previa	31	2.38%	24	1.92%	34	2.75%
Other Hemorrhage	62	4.77%	79	6.31%	111	8.99%
Rh Factor	------	------	26	2.08%	55	4.45%
Anemia of Pregnancy	10	0.77%	4	0.32%	2	0.16%
Pyelitis of Pregnancy	3	0.23%	1	0.08%	4	0.32%
Disproportion—Abnormal Position	38	2.92%	------	------	1	0.08%
Other Obstet. Complications	53	4.08%	76	6.07%	81	6.56%
Total Obstet. Complications	365	28.08%	401	32.05%	440	35.63%
Other Complications	162	12.46%	64	5.12%	77	6.23%
Total Complications	527	40.54%	465	37.17%	517	41.86%

TABLE 3.—SELECTED PREGNANCY COMPLICATIONS—RATE PER 10,000 LIVE BIRTHS—WISCONSIN RESIDENT DATA

	1946		1953*		1956	
Total Live Births	74,144		88,408		93,496	
Complication	No.	Rate	No.	Rate	No.	Rate
Accidents	1	0.1	24	2.7	39	4.2
Appendicitis	32	4.3	33	3.7	40	4.3
Congenital Deformity (Mother)	------	------	28**	3.2	42**	4.5
Diabetes	56	7.6	70	7.9	115	12.3
Eclampsia	181	24.4	37	4.2	39	4.2
Fibroids	25	3.4	58	6.6	41	4.4
Heart and Circulatory Disease	78	10.5	133	15.0	235	25.1
Nephritis (all)	79	10.7	82	9.3	78	8.3
Ovarian Tumor	1	0.1	17	1.9	23	2.5
Placental and Hemorrhagic Complication	440	59.4	602	68.1	884	94.8
Pneumonia	15	2.0	20	2.3	23	2.5
Poliomyelitis	------	------	28	3.2	29	3.1
Prolapsed Uterus	5	0.7	10	1.1	22	2.4
Syphilis	17	2.3	9	1.0	10	1.1
Thyroid Disease	14	1.9	20	2.3	16	1.7
Tuberculosis	19	2.6	31	3.5	23	2.5

*Year in which the Maternal Mortality Study was initiated.
**Includes Congenital Heart Disease—7 cases in 1953; 9 in 1956.

These trends in obstetrics should be of interest to physicians in Wisconsin and they might serve as a basis for local studies by hospital staffs.

Recommendations

1. All physicians are urged to support the teaching programs of the Division through participation in institutes on prematurity and maternal demise. Local hospital groups are likewise urged to initiate studies in their own hospitals, to review practices and experiences in these two areas.
2. Physicians not yet using the form "Prenatal Facts" are urged to do so. Hospitals are urged to organize their records so that this information properly filed in advance of the patient's anticipated confinement, can be used effectively in event of emergency.
3. Physicians in areas where migrant workers are in temporary residence are urged to assist in every way possible to provide prenatal care to pregnant workers or to pregnant wives of workers. They are also urged to transmit to proper medical or public health authorities medical records in event the pregnant woman leaves the area prior to delivery.
4. Hospital staffs are urged to study in particular the latter portion of this report dealing with trends in obstetrics. It is suggested that this report serve as the basis for further study of obstetrical practices in local hospitals and communities so that the common problems related to obstetrical care can be met most effectively with resulting salvage of life.

Respectfully submitted,

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P.S. Because of their outstanding success the Division believes that the House should take note of the recently completed series of maternal mortality institutes as reported on the following pages by Assistant Secretary Roy T. Ragatz.

REPORT TO THE SECRETARY ON 1958 MATERNAL MORTALITY INSTITUTES

PREFACE

"How much is a life worth?"

No monetary value can ever be placed upon a human life. Admittedly, the life of a mother has great value to the immediate family, and likewise to the

community in which she lives. The economics of family life are measurable, but the life of a mother in terms of child care is beyond measure. Any mother saved from death is of tremendous importance to the medical profession, and for that reason anything which can be done to eliminate maternal deaths is of great value.

It is, of course, impossible to place true value upon a study such as the Maternal Mortality Survey, but at times instances occur which indicate that in direct, as well as indirect ways, these programs are reflected in the saving of human life.

On March 6 the first of a series of teaching programs based upon the Wisconsin Maternal Mortality Survey was held in Madison. Among the topics discussed was that of blood loss and resulting afibrinogenemia. Suggestions were offered as to proper use of fibrinogen and the necessity for an early evaluation of the blood clotting mechanism in the event of conditions of pregnancy which are potentially associated with the defibrinization of the blood.

On March 14 a Madison physician who had attended this conference had a maternity patient about to go into labor. She had delivered precipitously on two previous occasions, and to "play safe" the family physician requested that she be admitted to the hospital for observation, even though evidence of impending labor was rather slight. After being admitted to the hospital she had some desultory labor pains, but they subsided and she went to sleep. The family physician returned to his home, hopeful that he might secure at least several hours of uninterrupted rest. At 4 a.m. he was phoned by the hospital and told that his patient had awakened, had two or three pronounced labor pains, and then had hemorrhaged with marked loss of blood.

At this point, let's hear from the doctor:

> "I was thankful that I had had such a recent review of afibrinogenemia and the necessity for prompt blood analysis in the face of a massive hemorrhage. I requested the hospital to immediately test the blood for clotability and to start transfusions while I was on the way. Whole blood was administered as an emergency measure. By the time I arrived at the hospital the lab analysis clearly revealed a depletion of fibrinogen, and we immediately started using what supply we had at the hospital.
>
> "This, plus an additional supply from the local Red Cross provided us on an emergency basis, saved the patient's life, even though the life of the infant was lost."

A dramatic situation, evidence of the value derived from a medical teaching program. How many more there are over the years is impossible to state, nor can we recount the many situations where emergencies did *not* arise because improved knowledge of eclampsia, hemorrhage, anesthesia, etc., provided the physician with weapons he could use early in the development of situations which if left unmet would have resulted in emergencies and possible tragedy.

MATERNAL MORTALITY INSTITUTES

MADISON March 6	MILWAUKEE March 13
WAUSAU March 20	EAU CLAIRE March 27

Few teaching programs conducted by the State Medical Society during the past decade have received such a warm response on the part of members as the Maternal Mortality Institutes conducted by the Study Committee of the Wisconsin Maternal Mortality Survey during March of 1958.

These teaching programs were provided as interpretations of special problems which have been revealed through the study since its inception in 1953, and to better acquaint Wisconsin physicians and nursing supervisors in Wisconsin hospitals with the work of the Study Committee and its desire to provide teaching material for the betterment of patient care.

The instructional programs were developed as an alternative program of illustrated lectures before hospital staffs conducted in 1955. It was felt by the Study Committee that more could be accomplished by having a series of panel discussions, with Study Committee members as members, than by individual presentations on the statistical portions of the Study. By combining the talents of the Study Committee members most directly associated with the instructional programs at the University of Wisconsin Medical School and Marquette (augmented by the services of Dr. Wm. Kreul, Racine, covering anesthesia problems of obstetrics) a program of varied and stimulating discussion was provided.

Publicity

Basically a publicity schedule comparable to that conducted in relation to Circuit Teaching Programs was carried out. An initial mailing to the entire membership was conducted on February 6. This was followed by special mailings to members of the Wisconsin Society of Obstetrics and Gynecology on February 17, and to members of the Wisconsin Academy of General Practice on the following day. A week before each institute a Reminder Notice was mailed to all physicians in the area of the meeting.

Hospital publicity was directed to Administrators and Chiefs of Staff on February 10, and a follow-up communication to all hospitals which had not registered personnel by March 7.

Sharing of Expenses

The cost of these programs was extremely small in comparison with contacts made and results achieved. Through the State Board of Health major costs of the preparation of programs and mailing of

the preliminary announcement to all physicians in the state, plus providing an honorarium of $100 for each of the speakers (to reimburse them for travel costs in covering the four meetings) were assumed without costs to the State Medical Society. The Society costs were those of postage for mailings following the first mass mailing, stock, travel of the Assistant Secretary to Milwaukee, Wausau and Eau Claire, and secretarial time in processing notices, preparing badges, etc.

The cost in relation to physicians and nurse supervisors served was extremely low, as costs of promotion were held to a minimum.

Response of Physicians

Listed below are the attendance records at the various institutes.

ATTENDANCE RECORDS
MATERNAL MORTALITY INSTITUTES—1958

	Physicians	Faculty	Med Students	Nurses	Staff	Total
MADISON (March 6)	86	5	4	36	2	133
MILWAUKEE (March 13)	94	5	12	56	1	168
WAUSAU (March 20)	56	5	1	38	1	101
EAU CLAIRE (March 27)	62	5	2	59	1	129
	298	(20)	19	189	(5)	531

It will be noted that physician attendance at each conference was commendably high. The meetings were all held on Thursday afternoons, when many physicians traditionally close their offices. The fact that no registration fee was charged contributed to the good response. Weather was not a competitive factor, as it was too early for golf or other forms of recreation which might have been chosen instead of attendance at the meeting. Category I credit for A.A.G.P. members further encouraged participation by generalists.

Numerous comments of physicians in attendance, complimenting the State Medical Society and the State Board of Health for providing such a practical teaching program, were most gratifying to members of the Study Committee who have given a great deal of time to this project since 1954. There were few who attended who did not stay until the entire program was completed, which gave testimony that the instruction was beneficial and well received.

The manner in which the meetings were conducted did a great deal to dispel any lingering notion that the purpose of the Study was that of investigation. All speakers conveyed the idea that the sole purpose of the Study was that of seeing what special problems in the field of obstetrics confronted the profession and hospitals in Wisconsin, and to provide ideas which might be translated into practice to better meet the emergencies which arise in the care of the obstetrical patient.

Future Developments

When a program achieves success there is always a tendency to continue it beyond the limit of maximum effectiveness. The four teaching programs covered most areas in the state, and provided an opportunity of attendance without undue driving on the part of the physician who really wished to attend. Possibly similar meetings in the Racine-Kenosha, Sheboygan-Manitowoc, Appleton-Green Bay-Oshkosh and La Crosse areas might be justified, in the event the county societies wished to have such instructional programs provided or developed as Councilor District meetings.

There are, however, logical continuations of the panel programs which might be further developed to "spread the gospel," and to continue physician attention to this important area of medical practice. It is recommended that some or all of the following be developed during the ensuing year.

1. *Tape Recordings:* Each member of the panel could provide a 15 to 20 minute informal talk on the subject covered at the institute, recorded on tape, and then have this followed by a "Question and Answer" period conducted by Doctor Leonard and the physician who presented the informal talk. These recordings could be made available to hospital staffs or even to individual members who would have access to a tape recorder for play-back purposes. A series of 5 or 6 such tapes, if properly promoted, might be of special service to small hospitals and to small county medical societies.

2. *"Obstetrical Briefs" in Question and Answer Form:* In every second or third issue of the *Wisconsin Medical Journal* there could be a page of provocative questions, and their answers, on a variety of subjects which have suggested themselves to the Study Committee during the past four years of case analysis. The subjects could be mixed each printing, so as not to concentrate on any one phase of obstetrics. Members of the Study Committee could prepare questions, as well as answers, and enlist questions from the membership, to make it a sort of "forum" on obstetrical problems.

3. *County Studies:* Four years of study of maternal deaths will provide an interesting analysis of where such deaths occurred, by counties. This might stimulate some counties to work with the Study Committee on county or regional review of all deaths studied to date in specific areas.

4. *Student Instruction:* The Study Committee could provide a stimulating and interesting panel program of several hours' duration at

both the University of Wisconsin Medical School and Marquette, either annually in May or periodically. The students of today will be confronted with the obstetrical problems of tomorrow and if they can be warned of the dangers of Pitocin, the hazards of Trilene in open systems of administration, the futility of "waiting it out" when eclampsia suggest immediate surgery, and dozens of similar problems, some material improvements in the care of the obstetrical patients in Wisconsin can be anticipated.

Summary

The Maternal Mortality Study has presented many problems, both to those engaged in the Study and the administrative staff of the State Medical Society. At times its continuance has been seriously questioned. In many ways it seemed to be in a "blind alley" until these teaching programs were conceived and initiated. The tremendous response of the profession to these instructional services has given the members of the Study Committee a feeling that their work and efforts have been of value, and that the Study should be continued. The meetings have brought physicians and nurse supervisors together, and the joint responsibility of the doctor-nurse-hospital in the care of the obstetrical patient has been re-emphasized. The interest shown by all those who attended indicates that this area of instruction cannot be over-emphasized. Support of continued and associated projects as outlined is worthy of consideration.

Respectfully submitted,

Roy T. Ragatz, *Assistant Secretary*

REPORT OF THE DIVISION ON NERVOUS AND MENTAL DISEASE

Mental health has recently blossomed into an object of legislative study and public concern. In an area of many unknowns, fact is piled upon fact, report upon report, prejudice upon prejudice, and opinion upon opinion. There is sufficient evidence of this illness to cause public awareness of a problem. There is enough known about diagnosis and treatment to stimulate confidence that something tangible can be done about the problem.

In the broad prospective this can be represented as progress. Yet the current result is an assortment of facts, a hodgepodge of opinions, and a general indecisiveness that has not yet established a pattern.

This observation prompts the Division to be reminded of an old maxim: "A little knowledge can be a dangerous thing." Legislative studies, public surveys, and general public opinion should move thoughtfully in this vast area of human behaviour. The current study of the Legislative Council in this field is beginning, and we sincerely hope will proceed, in this frame of mind.

Mental illness, as a condition of human health, should not be isolated from bodily illness. This concept is well-established as fundamental to the preservation of human health and to the diagnosis, care, and treatment of illness in the human being. This being so, your Division believes it equally fundamental that efforts to develop facilities, personnel and programs in areas of mental health must find their foundations in sound medical principles and health concept.

A focal point in the current concern about mental health is a proposal for the establishment of a treatment center for emotionally disturbed children in Wisconsin. On this problem your Division wishes to make a few generalizations which must pervade all discussion on this topic.

There are many facets to the problem of the emotionally disturbed child. The incidence of emotional disturbance in children touches every ethnic, religious, social, cultural and economic background. There is a multitude of different attitudes and opinions as to causation. Medical attitudes must be measured and joined with those of sociologists, psychologists, educators, the judiciary, and the clergy. From a scientific standpoint, it should be understood that basic research in a field of emotional disturbance is but newborn and, therefore, facilities should begin small and grow with experience. Further, the very nature of the condition often causes the adult to become as emotionally disturbed about the problem as the child is about himself and his relations with others.

The situation in the care of the emotionally disturbed child today might be likened to the status of tuberculosis treatment fifty years ago. Combined research, training and treatment have overcome fear and ignorance and brought tuberculosis to an entirely controllable stage. Tradition has established mental disease as something to be handled by commitment, a carry-over from the days when the jailhouse was thought to be the only proper place for the insane.

But mental illness is a state of health, not a violation of law. Its prevention and treatment must be regarded in the highest health sense if those who are or might be afflicted can be expected to willingly and voluntarily accept preventive and therapeutic measures.

With regard to the proposed treatment center for emotionally disturbed children, the Division and its Subcommittee on the Disturbed Child have been most active in meeting with the Legislative Council Committee on Mental Health, the Wisconsin Association for Mental Health, and representatives of the University of Wisconsin-Marquette University Medical School, the State Department of Public Welfare, the State Board of Health, and the State Department of Public Instruction. In general, the Division has concluded that:

1. There is genuine need for the development of a special state treatment fa-

cility, well-integrated with other mental health facilities, for the severely emotionally disturbed child.

2. In the beginning such a facility should be relatively small (perhaps 25 to 30 beds) and so designed as to allow expansion as experience and staffing permits.
3. The unit should preferably be University centered and medically oriented so that teaching and research opportunities can be utilized to the fullest while at the same time meeting service needs of the state to the best of its ability. In any event, the treatment center must be closely allied to the Medical School for teaching and research purposes.
4. The center should have its emphasis on health care rather than corrections. It requires medical direction and its health concept requires a broadened policy of admissions.

The Division is continuing its meetings with representatives of the University of Wisconsin Medical School and the several state departments involved. It anticipates that the Legislative Council Mental Health Committee will provide an opportunity for the Division to express its opinions at some appropriate point in its deliberations. It is possible that the Division may have a supplementary report to present to the House of Delegates.

In any event the Division points out the necessity for regarding the proposed treatment center as one part of the total efforts of the private medical profession, child guidance centers, local hospitals and county institutions, group homes, foster homes, the diagnostic center, the state's two University medical schools, and a number of state departments. The closest kind of coordination and cooperation between these elements of facilities and personnel is essential for the proper handling of the mental health problem, not only for the disturbed child but for all the citizens of the state.

Although the question of mental health and the emotionally disturbed child has occupied a large portion of the Division's time and effort during the past year, a number of other interests have been pursued.

The Division recommends that all county medical societies and voluntary health agencies in Wisconsin become fully acquainted with and attempt to implement to the fullest the American Medical Association guiding principles for relationships with voluntary health agencies.

A Subcommittee on Tranquilizers has been established to study this subject in Wisconsin and develop a report for submission to the *Wisconsin Medical Journal* and possible presentation to the teaching programs of the state.

The Subcommittee on Psychiatric Training has been reactivated in the hope that it can provide added impetus to plans for expansion and improvement of the psychiatric training program at the University of Wisconsin Medical School.

Likewise the Committee on Commitment Laws has been reactivated for the purpose of exploring the problem of "insanity before the court."

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REPORT OF THE COMMISSION ON MEDICAL CARE PLANS

The Commission, through the House of Delegates and the Council, is responsible for the operation of not only Wisconsin Physicians Service, the Blue Shield Plan of the State Medical Society, but also for other related insurance activities such as the Wisconsin Veterans Medical Service Agency, the Wisconsin Plan, Medicare, and advising the Wisconsin Interscholastic Athletic Association. Through the mechanism of the Commission, the Society can bring about a consistency of administration in claims and fee schedules, a sense of direction toward the goals of the Society for health insurance and a uniform application of the policies established by the House of Delegates and the Council in the Society's insurance programs.

The Principal Becomes Its Own Agent

To the medical profession, the word "principal" is perhaps more often considered as the constituent which characterizes a substance or gives that substance its essential properties or character. The principal is the activator. It is the creator. It is the real source; life-giving impulse.

The word "agent," on the other hand, is something which carries the essential property into force, and in the legal sense, an agent operates only through the authority delegated or conferred by the principal. This may be either limited or qualified, but is always within the principal's authority to define, to state, or to recall. The principal, not the agent, has the right to say whether it wishes an agency to continue.

When Wisconsin Physicians Service was first organized, it employed Blue Cross in a limited agency capacity. Blue Shield of Wisconsin retained full authority for certain matters relating, for example, to advertising. It retained the sole judgment on claims handling. It retained contract terminology and contract benefits. But it delegated to Blue Cross, under a formula for reimbursement, the responsibility of selling; and after a group was sold, the responsibility of enrolling members of that group; and following that, the collection of the rates applicable to a particular group. There were certain incidental functions involved in that agency contract other than those enumerated, but these are the most important and constituted the basic relationship between Blue Cross of Wisconsin and Blue Shield of Wisconsin.

In 1954 the prior agency contract was rather substantially revised and a new rate of reimbursement to Blue Cross was agreed upon. Blue Shield felt the rate to be adequate, even generous. But in the fall of 1956, Blue Cross notified Blue Shield that it wished to renegotiate the rate and secure a still greater reimbursement for its services. Under the agency contract negotiated in 1954, if parties to the contract were unable to agree upon its terms in the event of renegotiation, an automatic termination provision became operative. Blue Shield of Wisconsin did not agree to the position taken by Blue Cross that the latter should be paid more money. By the end of July, 1957, the automatic termination provision of the contract was invoked, neither party assuming a greater or lesser responsibility than the other for failure to reach that agreement. Negotiations were reopened, on a limited basis, in late August and continued until late September 1957, but it then became apparent that Blue Shield would become, as principal, responsible for all the functions previously delegated to Blue Cross under the agency program. This it has done through the employment of individual agents or representatives who are distributed in various areas of the state, and through establishment of enrolling and billing functions within the Society office.

Another major element has entered the picture that was not apparent in 1954. The development of the Special Service Contract, its wide acceptance, and the consequent decentralization of much of claims administration has required Blue Shield that it develop a field service on a broader basis than that of sales representation alone. Other portions of this report deal more intimately with the problem of the Special Service Contract, and it will be noted from it that working closely with the groups possessing the benefits of such a contract and with the local medical profession, is an integral part of the program—essential, in fact, to its very success.

However, Blue Shield of Wisconsin acknowledges that Blue Cross is a program associated with it in the over-all objectives of providing the people of Wisconsin with voluntary, sound, and highly beneficial types of protection against the costs of illness and accident. Blue Cross is the hospital plan and is concerned with the area of hospitalization. Blue Shield is the doctors' plan and is concerned with the entire field of the professional care of the patient by his physician or physicians, as the case may be.

Special Service Contracts Grow

Growth is a commonly accepted measuring stick for the success of any program in the health insurance field. For its part, Blue Shield of Wisconsin has progressed, not rapidly but steadily towards its current coverage of more than 350,000 persons in Wisconsin. Perhaps of greater importance to both the public and the physician is the change in character of Wisconsin Physicians Service coverage over the last ten years. Today, even the nation is watching the progress of the Special Service Contract which is sometimes designated as the "No Fee Schedule" coverage of Wisconsin Physicians Service.

The Special Service Contract was a product of many factors. The Commission regards it as an answer to the confusing complexity of multiple income levels and fee schedules. It is a return to the concept, so fundamental to the profession, that medical care in all of its aspects is a relationship between the patient and the physician. Further, it is greater recognition of the public's right to and demand for the opportunity to realistically budget its health care expenses.

Under this completely new concept of health care insurance the Special Service Contract provides maximum benefits of $1,000 or $10,000 per person for each illness according to the contract selected by the subscriber. Most payments under the plan are made according to the "customary, usual and reasonable" charges of physicians for their professional services. This means that Blue Shield of Wisconsin will pay the physician at a rate that does not exceed the general level of charges by others who render such services under similar circumstances within the community in which the charge is incurred.

In Special Service, Blue Shield of Wisconsin pays the reasonable charges of physicians (including assistants and consultants) to provide protection against the costs of surgery, medical care in the hospital, Cesarean, ectopic pregnancy and miscarriage (a $75 or $100 cash allowance for all other maternity services), anesthesia and diagnostic x-rays associated with surgery or maternity, and radiation therapy for malignancies except of the skin. Additional coverage for related medical services is available at nominal cost. The Special Service Contract is the basic portion of a Major Illness Plan also offered by Blue Shield of Wisconsin for those who wish to purchase it.

In any event, the Special Service Contract is competitive as to price with the "A" and "B" programs and with other insurance programs offered by private carriers.

It is obvious from the description of this program that the Special Service Contract requires an unusual degree of close cooperation between the group which purchases the coverage and the county medical society of the area in which the coverage is in effect. This close relationship between sales and servicing is, in fact, the heart of the Special Service Contract.

Since payments under the plan are made according to the "customary, usual and reasonable" charges of the physician, it follows that any differences over charges will be handled by an appropriate committee of the county medical society most directly concerned with the person covered. As a rule these differences are minimal and the cooperation of physicians throughout the state has been nothing short of magnificent. Perhaps this can best be illustrated by quoting the Second Annual Report of the Insurance Advisory Committee of the County Medical Society of Racine where the first Special Service Contract went into effect.

"1957 Report of the Insurance Advisory Committee of the Racine County Medical Society November 21, 1957"

"At the end of two years the members of your committee are pleased to report continued success of the no-fee schedule Blue Shield contract. The number of such contracts in force in Racine is now ten, twice that of a year ago. Contracts are in force elsewhere in the State—Kenosha, Madison, Eau Claire. The Medicare Program for Wisconsin was negotiated successfully by the State Medical Society on the same type of no-fee schedule plan. Recently our county society has subscribed to the extension of the principle for the recipients of Public Welfare and Social Service assistance.

"The number of meetings of the committee required in the past twelve months was less than in the previous twelve months. In addition the actual number of cases requiring review each meeting was less. Had the problems as outlined in the report of a year ago been solved, the number of cases for review would have been reduced further.

"As a matter of record the committee wishes to review principles established in the course of the workings of the committee. Firstly, the function of the committee is advisory and not judicial. The committee is not a type of grievance committee. The principle of the type of insurance plan that it serves is so right that the committee has been needed only to explain, mediate, arbitrate.

"In the past decade higher wages have brought greater comforts and pleasures to the average family but have not paid for medical care proportionately. This has been the concern of government, labor and management circles as well as medical. The result has been prepay health insurance. It might have been government medicine. Looking back ten years the rate of growth of insurance, as well as its rapidly increasing quality, has been phenomenal. The cooperation of doctors is essential. Only doctors know the problems and doctors are needed to solve them.

"Insurance does not alter the doctor's responsibility to his patient in the matter of fees. Insurance should not and must not increase the cost of medical care. The patient still pays the bill.

"Insurance can be written on the no-fee schedule basis because most procedures are done on average patients with an average ability to pay by doctors having similar experience and skill.

"A no-fee schedule principle protects the doctor's right to set his fee in each case. A range of fees is essential to the philosophy of the terms usual, customary and reasonable.

"The determinants of fees in the individual case include: the difficulty of rendering the service; the skill required of the doctor; the financial ability of the patient to pay; what others in the community charge. These considerations are based on a legal study of Wisconsin and other court decisions as well as relevant legal text on the subject.

"The need for elaboration of services rendered is apparent and this committee enjoins the doctors to do so in making out their reports. Adequate reports have reduced the cases requiring review by the committee.

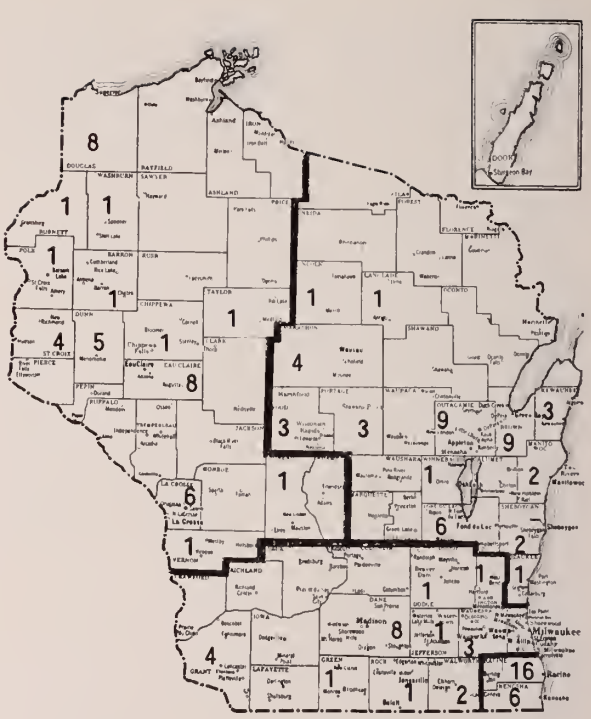
"Preoperative and postoperative care, when usual, is customarily, here and elsewhere, included in the surgical procedure fee.

"This committee is currently concerned with the following problem. In the ordinary uncomplicated surgical procedure when rendered by a family physician and a surgeon or specialist as opposed to being rendered by a surgeon or specialist and his assistant, the cost is sometimes greater. A comparable service should cost the same regardless of the extrinsic conditions under which the service is rendered. Each participant should be reimbursed according to his contribution to the total service. This partition should be determined by conference of the participants so that the patient will receive an equitable bill and not inadvertently be overcharged. This principle is valid whether it involves insurance or not. If this problem is not solved in the near future, it will

jeopardize and may defeat the no-fee schedule plan. This committee recommends to the president of our society that a special committee composed of surgeons and general practitioners be set up to study the problem and make recommendations.

Respectfully submitted,
INSURANCE ADVISORY COMMITTEE
RACINE COUNTY MEDICAL SOCIETY"

The number of groups covered by Special Service Contracts has nearly tripled since January 1, 1958. At the start of the year, 48 groups had the coverage. As of April 1, about 130 groups in Wisconsin have purchased the Special Service Contract. This means that nearly 13,000 contracts are now in effect covering more than 30,000 persons. A map accompanying this report indicates the extent of coverage of Special Service Contracts in Wisconsin. The numbers in each county indicate the number of groups. Reviewing these installations by area, it should be noted that the Green Bay Blue Shield District has 45 groups covered by the Special Service Contract; the Eau Claire District has 39 groups covered; the Madison District has 22 groups; and the Kenosha District has 22 groups.



Wisconsin
LOCATION OF SPECIAL SERVICE GROUPS

Promotion

Promotional activities of Blue Shield of Wisconsin have been markedly increased. Special literature has been designed to improve public understanding of the benefits provided, the contracts and coverage available, and how to utilize Blue Shield identification cards to expedite claim handling. It should be pointed out that the efforts of Blue Shield of Wisconsin in the sales and promotional fields have been marked by a distinct support of Blue Cross as a companion plan for hospitalization protection. Both group and non-group literature contains specific reference to the advisability of purchasing Blue Cross for hospital protection. The same philosophy is carried throughout the sales area of Blue Shield of Wisconsin by its sales and field service staff. This assures a close tie-in with the national Blue Shield and Blue Cross advertising which provides separately identified but jointly presented advertising in many popular and nationally distributed magazines. A recent example of national advertising, the spirit of which is carried out in all Blue Shield sales and promotional efforts, is shown in the attached advertisement from a national business publication. (See next three pages)

Coverage and Claims Functions

The latest administrative addition to Blue Shield of Wisconsin is the enrollment and billing process which has been in full operation in the Society office since February 1. Now, for the first time, Blue Shield of Wisconsin has full and complete information on the groups and subscribers covered by its own programs.

On the claims side of the Blue Shield of Wisconsin operation, the volume continues to grow. In 1957 the Claims Department processed a total of 106,362 cases involving 128,632 procedures. The volume of claim payments for 1957 totaled $4,223,932 as compared to $3,885,737 in 1956. Effective December 1, 1957 physicians began originating claim forms (Physicians Service Reports) on all claims for benefits. Previously, physicians originated claims only on home and office medical cases. Simultaneously, an extensive subscriber education program was undertaken with the development of posters and literature to subscribers and groups to encourage subscribers and their families to inform physicians of their Blue Shield coverage at the time they requested services. A close and continuing liaison is maintained with county medical society insurance advisory committees in areas where Special Service Contracts are in effect.

Nation's Business

A USEFUL LOOK AHEAD NOVEMBER 1957

Know yourself, understand others: a test PAGE 32

Every sale can pay its way PAGE 58

Job analysis saves managers' time PAGE 70

"BLUE CROSS know-how helps us offer outstanding protection against unexpected hospital bills!"

Says **HARRY ROLNICK,** *President, Resistol Self-Conforming Hats, Inc.*

Harry Rolnick exhibits hats from his museum in Garland, Texas and is holding his own modern creation, the "Flat Top."

"When our company decided to have a program of hospital care benefits, we wanted the best. Of course, we couldn't become hospitalization experts overnight, but we did the next best thing. We went to our local Blue Cross people. Their long and specialized experience paid off for us. They were able to help us work out a program that pleases our employees."

Blue Cross Plans, serving locally coast to coast, bring Americans this famed program for prepayment of hospital care . . . the only one officially approved by the American Hospital Association.

BLUE CROSS PLANS pioneered group prepayment for the cost of hospital care. Starting in 1929, Blue Cross has grown to a present membership of over 55 million. Here are some of the reasons why:

A unique basic aim. Blue Cross Plans emphasize the actual care of the individual—rather than the payment of dollar allowances. Benefits are designed to meet the needs of the patient.

Convenience for employees. When being admitted to a participating hospital, the employee simply shows the Blue Cross card. Blue Cross Plans work closely with participating hospitals—as in a partnership. They alone are officially approved by the American Hospital Association.

Efficiency for management. Because of the way Blue Cross Plans work directly with hospitals, your company need not get involved in cases. There are no claims to file. You have no extra paper work, no follow up.

Full flexibility. Blue Cross protection can be easily adapted to fit your company's employee welfare objectives, whether broad or limited. You'll find that Blue Cross can be integrated in almost any benefit "package."

Sound economics. Blue Cross can give you and your employees more for the money. Except for low administrative costs and reserves, all money paid in is set aside for members' hospital bills.

Check the facts! For full information on the many advantages of Blue Cross for employees and management, contact your local Blue Cross Plan. Or write directly to *Blue Cross Association, Inc., Dept. 423, 55 East 34th St., New York 16, New York.*

Typical of the leading companies having Blue Cross:

AMERICAN PRESIDENT LINES
CHRYSLER CORP.
CROWN ZELLERBACH CORP
J. STEVENS ARMS CO.
RAYTHEON MFG. CO.
R. G. LeTOURNEAU, INC.
SCOTT ATWATER MFG. CO.

BLUE CROSS®

*Blue Cross and symbol registered by the American Hospital Association.

HARRY ROLNICK, *Pres., Resistol Self-Conforming Hats, Inc., says:*

"Doctors' backing gives ***BLUE SHIELD*** *special value for our employees!"*

"Doctors in our area enthusiastically approve of Blue Shield. This certainly convinces our employees that they've got the best protection—and it assures us that we made the right decision in choosing Blue Shield."

Doctor approval. All Blue Shield Plans are sponsored or approved by state or county medical societies. Broad Blue Shield benefits include hundreds of operations as well as many nonsurgical services.

Management advantages. Blue Shield pays directly—no claims to file, no time-consuming bookkeeping.

Cost is low for the protection Blue Shield gives. All money taken in by a Blue Shield Plan, except for necessary expenses and reserves, goes toward paying members' doctor bills.

Adaptable. Blue Shield can fit the aims of large or small companies.

To get answers to your questions, contact the Blue Shield Plan in your area. Or write *Blue Shield Commission, Dept. 423, 425 North Michigan, Chicago 11, Illinois.*

BLUE SHIELD®

*Service marks reg. by Blue Shield Medical Care Plans

WISCONSIN PHYSICIANS SERVICE

A Division of the State Medical Society of Wisconsin
Madison, Wisconsin

COMPARATIVE STATEMENT OF INCOME AND EXPENDITURES
Years Ended December 31, 1957 and 1956

	1957	1956	Increase or (Decrease)
INCOME			
Earned Premium Income	$5,309,753.78	$4,975,963.97	$333,789.81
Less: Benefits Incurred	4,428,840.57	4,170,269.88	258,570.69
Available for Expenses and Res.	$ 880,913.21	$ 805,694.09	$ 75,219.12
ADMINISTRATIVE EXPENSES			
Agents' Expenses	$ 374,985.15	$ 349,032.66	$ 25,952.49
Salaries	236,952.00	177,356.42	59,595.58
Payroll Taxes	6,585.63	3,556.98	3,028.65
Employees' Group Insurance	7,087.77	4,824.07	2,263.70
Retirement Plan Contributions	4,911.12	3,544.58	1,366.54
Actuarial Services	4,310.84	5,928.48	(1,617.64)
Accounting Services	8,224.10	5,531.67	2,692.43
Legal Services	15,166.22	12,108.86	3,057.36
Conference Expense	16,454.39	20,889.80	(4,435.41)
Travel Expense	20,462.04	18,516.55	1,945.49
Association Dues	10,685.72	9,307.99	1,377.73
Promotion	6,448.54	10,546.44	(4,097.90)
Amortization of Leaseholds	1,000.00	1,000.00	----------
Depreciation	5,682.43	3,661.59	2,020.84
Insurance	2,065.39	2,005.48	59.91
Office Supplies and Expense	7,955.44	5,408.34	2,547.10
Postage	9,809.75	7,714.34	2,095.41
Printing and Forms	15,736.31	9,487.83	6,248.48
Rent—Office	58,856.80	51,608.94	7,247.86
Rent—IBM Equipment	14,004.57	11,053.36	2,951.21
Telephone and Telegraph	5,960.91	3,872.08	2,088.83
Other Administrative Expenses	5,627.95	4,165.98	1,461.97
Total	$ 838,973.07	$ 721,122.44	$117,850.63
Less: Expenses Reclassified	29,773.84	2,616.89	(27,156.95)
Total Administrative Expenses	$ 809,199.23	$ 718,505.55	$ 90,693.68
Net Operating Income	$ 71,713.98	$ 87,188.54	$(15,474.56)
OTHER INCOME			
Administrative Income	3,180.35	3,269.15	(88.80)
Investment Income	73,578.69	60,415.63	13,163.06
Total	$ 148,473.02	$ 150,873.32	$(2,400.30)
SPECIAL EXPENDITURES			
Northwestern Wisconsin Experiment	$ 8,437.43	$ 9,519.26	$(1,081.83)
Mobile Unit	12,469.12	10,873.30	1,595.82
Grants and Appropriations	5,000.00	5,000.00	----------
Development Expense	48,631.50	----------	48,631.50
Termination Expense	32,819.54	----------	32,819.54
Total	$ 107,357.59	$ 25,392.56	$ 81,965.03
Available for Reserves	$ 41,115.43	$ 125,480.76	$(84,365.33)

CONDENSED COMPARATIVE STATEMENT OF INCOME AND EXPENDITURES, EXPRESSED AS A PERCENTAGE OF EARNED PREMIUM INCOME

Years Ended December 31, 1957 and 1956

	1957	1956	Increase or (Decrease)
INCOME			
Earned Premium Income	100.00%	100.00%	%
Less: Benefits Incurred	83.41	83.81	(.40)
Available for Expenses and Reserves	16.59%	16.19%	.40%
ADMINISTRATIVE EXPENSES			
Agents' Expenses	7.06%	7.01%	.05%
Other Administrative Expenses	8.18	7.43	.75
Total Administrative Expenses	15.24%	14.44%	.80%
Net Operating Income	1.35%	1.75%	(.40%)
Other Income	1.45	1.28	.17
Total	2.80%	3.03%	.23%
Special Expenditures	2.02	.51	1.51
Available for Reserves	.78%	2.52%	(1.74%)

BALANCE SHEET

December 31, 1957

ASSETS		
Cash on Hand and in Banks		$ 404,440.41
Due from Agents	$ 165,634.22	
Refunds Receivable—Net	819.00	
Due from Medicare—Advances $60,000.00		
Due from Medicare—Current 30,206.34	90,206.34	
Other Accounts Receivable	1,248.17	
Total Receivables		257,907.73
U. S. Government Securities—Book Value	$2,469,335.27	
Less: Excess of Book Value over Market Value	11,168.27	
Securities at Market Value	$2,458,167.00	
Mortgage Loans	276,000.00	
Land and Buildings—Net	25,405.62	
Total Investments		2,759,572.62
Leasehold Improvements—Net	$ 22,500.00	
Office Furniture and Fixtures—Net	65,825.07	
Autos and Trailer—Net	6,586.92	
Total Fixed Assets		94,911.99
Accrued Interest Income		14,089.99
Deferred Charges		7,647.24
TOTAL ASSETS		$3,538,569.98
LIABILITIES AND RESERVES		
Accounts Payable		$ 38,672.49
Merit Rating Credits Payable		12,650.43
Applicants Premium Deposits		1,399.74
Provision for Incurred Claims Unpaid		717,700.00
Old Outstanding Checks		5,542.50
Unearned Premiums		433,155.33
Other Deferred Income		1,400.00
TOTAL LIABILITIES		$1,210,520.49
Reserves—Maternity Benefits	$ 264,400.00	
—Disaster Benefits	509,379.00	
—Major Illness Expense	100,000.00	
—Unforeseen Contingencies	329,342.24	
—Administrative	900,985.24	
—Investment	223,943.01	
TOTAL RESERVES		2,328,049.49
TOTAL LIABILITIES AND RESERVES		$3,538,569.98

NOTE: Securities are shown above at market values. The recovery in market values during 1957 in the amount of $41,018.57 has been credited directly to the Investment Reserve, to which reductions in market values were charged previously. These variations are not reflected in the Statement of Income and Expenditures.

MEDICARE

Medicare is essentially a program by which certain dependents of active duty servicemen may obtain in-hospital surgery and medical care, treatment of accidental injury, and obstetrical and maternity care, in addition to certain other specified procedures, at government expense. On December 7, 1956, the State Medical Society of Wisconsin began operating as the government agent for processing Medicare claims in Wisconsin.

During the year 1957 somewhat more than 4,000 Medicare claims for services rendered by Wisconsin physicians were processed through the Society office. These claims resulted in the payment to physicians of $283,000.

Seen as a part of the total medical care rendered by Wisconsin physicians, Medicare is almost minuscule. The experience it has provided, however, as a demonstration of government-operated medical care plans and as a potential for expansion to other groups of the population, poses a substantial challenge to the profession.

To illustrate: In late 1956 and after long and arduous negotiations, Wisconsin signed a Medicare contract with the Federal Government providing for payment of physicians' customary and usual charges within a maximum which was sufficient to enable payment of charges as determined by the complexity and circumstances of the service, the geographical area of the state, and personal considerations for the patient. This approach to fees is under constant threat from the government, with repeated efforts to restrict, limit or control the application of the basic principle without giving it an opportunity to prove itself.

During the first year of Medicare's operation the State Medical Society of Wisconsin, because of its facilities for machine and clerical services became a sub-contractor for certain of these services for five neighboring state medical societies. Wisconsin is reimbursed for the costs involved. The Society entered these agreements not only because they lack facilities within their own organizations, but in recognition of an obligation to a neighbor of the same profession in light of problems that are common to all medical societies in dealing with third party programs.

The Wisconsin Medicare contract with the Federal Government came up for renegotiation in January, 1958. The Society was represented in Washington by three physicians accompanied by staff, accounting and legal consultants. From the outset it was obvious that primary emphasis was to be placed by the government negotiators, headed by General Robinson of the Office for Dependents' Medical Care, on a re-analysis of the fee schedule amount previously negotiated for each procedure. The government is apparently striving for as great a degree of uniformity as is possible with the state medical societies and some Blue Shield plans which administer Medicare. To that end, Wisconsin was requested by the government to subdivide its surgical fees which originally included complete care—pre- and post-operative care as well as surgical service. Medicare officials requested that this fee be subdivided into component parts of different fee schedule maximums for surgery, ordinary postoperative care in the hospital and post-hospital visits.

This segmentation of surgical fees was regarded by the Wisconsin negotiating team as unsound and highly objectionable. In line with the principle of "reasonable charges," the Society has taken the position that doctors be reimbursed on the basis of "services rendered" regardless of partial or full service. A subdivision of the complete fee and the component parts could ultimately lead to renegotiation at some future date of one or more of the components with the end result that adjustment would finally be requested in the fee for total care.

The significance of the government's attempts to segment surgical fees is emphasized in the following excerpt from discussions of the Society's Medicare Committee at which government representatives were present:

Statement by Secretary Crownhart to Medicare Committee and Colonel Richards re: Segmentation of Surgical Fees

March 15, 1958

Doctor Casper: I would like to hear from Mr. Crownhart on the reasons for the Society's objection to this portion of the contract.

Mr. Crownhart: It isn't a simple subject to discuss. I think, basically, it is abhorrent to the medical profession to hold that a total surgical procedure, all the way from diagnosis, operation, postoperative care in the hospital, and then postoperative care following hospitalization, is a type of service which can be divided, segmented, according to a predetermined formula. It has never been agreed in the medical profession, except in some local areas, but I am talking about the profession generally, that a percentage arrangement determines the value of partial service.

You have held in the medical society, you have held through the Judicial Council of the AMA, and in that you have been consistent with the American Bar Association, that those who participate in total care should be reimbursed pursuant to the value of service rendered. Thus, in the legal profession it is unethical and improper for an attorney who forwards a bill for collection to another attorney, to charge a fixed percentage for his own service. He can charge for the service he performs in working with the other attorney, but to charge on a percentage basis, predetermined, is unethical and improper for many reasons.

Now Medicare, insofar as it directly affects the economics of medical practice in Wisconsin, is not particularly substantial. But Medicare as it stands as a possible pattern for other governmental con-

tracts is highly important. We are under limited forms of contract with the State Department of Public Welfare for the care of certain categories of the disabled falling within its supervision. Practically every county medical society has negotiated, with local relief officials, a so-called schedule of benefits or fee schedule for the care of the indigent. I think there are probably 70 or 71 of those contracts in effect in Wisconsin affecting many thousands of people, and perhaps, unless the recession seems to terminate, perhaps many more thousands.

It has been suggested that the federal government, with unlimited power of taxation and having all the attributes of the sovereign power of government, need not purchase insurance in protection of its potential loss, because through taxation it can postpay such costs. That very statement was made in testimony on P.L. 569.

So it has been suggested that through a contract of similar character, government employees of the federal government might well be included, of course not under the Army, but under some other agency, and it has also been suggested that the same thesis be extended to state and municipal, including city, employees.

Now in my representations to General Robinson—as Colonel Richards pointed out—sometimes we get involved in semantics with one person meaning one thing and the other taking a different construction from a particular phrase used, and I am agreeable to that conclusion because it frequently occurs—what I have tried to present to the Army is that the Wisconsin concept of paying the value of the service rendered eliminates the need, and as a matter of fact destroys the need of proceeding to price a portion of the service rendered.

Therefore, if Doctor S., for example, performs a surgical operation and let's say provides a portion of the postop care, but not all of it, we are in a position to pay Doctor S. the value of the service that he performed and any subsequent physician in attendance on the case the value of the service he performed.

What I have tried to say to General Robinson, and as a matter of fact I would prefer to refer to him as Doctor Robinson, is that Wisconsin, and I think some of the associated states, are trying to pay more than lip service to that principle of medical ethics that holds that arbitrary values on service are abhorrent to the true professional man.

Now if in our contract with the federal government we had a fixed fee schedule in which we paid, let's say $100 for an appendectomy no matter how difficult or how easy, I think that I would have some difficulty justifying the views that I have expressed to General Robinson. But instead we have created with the contract a maximum control, and only in relatively few cases have we ever bumped our heads against the ceiling.

We are not paying the same price per procedure, either total or partial, because we are relating it to the customary and usual charges of the medical community. Personally, I am very proud of my own profession and I am very proud of the medical profession for holding that a physician or a lawyer ethically can bill value only and that his services are not price-tagged as they might be were they a commodity in a supermarket.

That concept we are trying to preserve, not because with Medicare it is going to hurt the patient or the doctor, but because that is a concept that is good for people and good for the physician, and it is a concept that should prevail in Medicare, Home Town Care of the Veteran, our Blue Shield program and 70 contracts with county governments for the care of the indigent in certain areas with welfare. We don't think that a rigid rule should replace a principle of medical ethics which has developed from many centuries of experience in patient welfare. This, I hope, may be a better statement that I put in the letter that was directed to Doctor Robinson on February 11 of this year.

Segmentation of fees in the Medicare program may at first seem relatively minor. However, it has been broadly suggested from numerous sources that contracts similar to Medicare for military dependents should be negotiated for federal government employees and that a similar pattern should be used for other employees or governmental "wards" at the state or municipal level.

This makes all the more important several other observations noted in the Medicare negotiations:

1. The Government initially requested, but withdrew under protest from Wisconsin, the inclusion of certain statements in fee schedules which had the effect of specifying "quality" in medical care. In one instance statements associated with the schedule of benefits were to specify that sufficient care be exercised to minimize radiation exposure to Medicare patients in all x-ray examinations. Wisconsin suggested that Medicare officials were contemplating more control than might meet the eye. For example, would they later order consultation for certain cases, such as Cesarean. While this may be good practice, it is one to be handled through a local hospital staff and in medical areas where it can be applied realistically and in light of community needs.
2. The Federal Government has suggested that certain procedures be followed to preserve ethical standards. The State Society has reminded the Federal Government that it is not the judge of the profession's ethics; that this is a matter for local concern and action and that the Society is fully capable of actively implementing the ethical standards of the profession in Wisconsin.

3. Medicare officials had been advising "free lance" nurse anesthetists as well as "free lance" physical therapists that they may directly bill the hospital's contractor for their services. This not only affects state laws and regulations pertaining to licensure but denies the physician utilizing such "free lance" individuals opportunity to continue to do so. It relegates a phase of medical practice to the hospital. On these points the State Medical Society of Wisconsin has registered strong protest, to which, in most cases, the Federal Government has, at least temporarily acceded. The handwriting, however, is clear. The effort that the State Medical Society of Wisconsin is currently making in the Medicare Program may be establishing a pattern and a standard which will guide expanded programs of this kind in the future.

The many meetings of the Medicare Committee of the Commission and the two negotiation meetings with the Federal Government in Washington on the subject of Medicare have absorbed untold hours of time on the part of physician committees, the staff and consultants. This report on their work with Medicare obviously stresses problems and deficiencies. In all fairness to government officials, however, the Commission can also report that as to the administrative area involved in the contract it has found cooperation as well as speed in working out some of these problems.

At the same time it must be recognized that policy cannot be wholly separated from the activity of the administration. If administration is not handled in close liaison with physicians and the Medical Society administration itself, policy efforts will be defeated. Unrealistic direction by federal officials unacquainted and unfamiliar with the problems of providing and administering medical care can lead the Medicare program and similar efforts into the no-man's-land of bureaucracy.

Only through continued diligent effort by the Medicare Committee and the staff, acting upon direction of the governing bodies of the Society, will the development of these socio-economic contracts be kept within the proper perspective of medicine.

HOME TOWN MEDICAL CARE

A year ago, at the time of the House of Delegates' meeting, the Society was negotiating with the Veteran's Administration to continue the arrangement which permitted the Society to provide home town care for veterans with service connected disabilities. The ten year agreement with the Society seemed to be in the balance.

The negotiations were concluded in a manner which permitted the Society to continue its "intermediary" arrangement with the Veterans Administration. The major result was a change which placed the physician in more direct contact with the Veterans Administration, particularly on the matter of receiving authorization for treatment.

In addition, and since the 1957 session of the House of Delegates, the Veterans Administration eased its limitations on authority for treatment. As a result, the Veterans Administration now authorizes treatment for chronically ill veterans with service connected disabilities on a long term basis rather than requiring renewal of the authorization every thirty days. This has proved to be a most practical step in eliminating paper work and facilitating rapid and continuing treatment.

During 1957 the Veterans Administration authorized Wisconsin physicians to provide treatment valued at $159,026.45. A total of $20,005.25 in authorizations for treatment were ultimately cancelled because physicians, although authorized to render the treatment, felt it unnecessary.

Also during 1957 the Veterans Medical Service Agency received and paid to Wisconsin physicians a total of $111,041.05 for medical services rendered on behalf of eligible veterans. As reimbursement for providing its administrative and advisory services to the home town care program, the agency was paid a total of $17,115.33 in 1957.

Once again the annual renegotiation of the agency agreement with the Veterans Administration is underway, this time with a view to continuing the program beyond June 30, 1958. As an element of this renegotiation, the Commission proposes that the Veterans Administration fee schedule for Wisconsin be reviewed.

OTHER INSURANCE ACTIVITIES

The Commission on Medical Care Plans continues to advise the Wisconsin Interscholastic Athletic Association on claims and other elements of its athletic insurance program. Of special interest to members of the State Medical Society should be the WIAA "no fee schedule" contract for athletic injuries which is reported to be covering nearly 45,000 students in Wisconsin. In general, this program has proved satisfactory although it is scheduled for some review and possible revision. The Commission hopes to be able to discuss the program in detail with WIAA officials during the coming year.

RADIOLOGIC COVERAGE GROWING

The Commission has directed that all future offerings of Wisconsin Physicians Service provide benefits for radiation therapy of proven malignancies other than those of the skin.

The benefit covers professional services rendered as well as x-ray, radium, or radioactive isotopes used in the treatment. Under the "A" and "B" programs of Wisconsin Physicians Service, the benefits will be provided on a scheduled basis. On the Spe-

cial Service Contracts benefits will be provided on the basis of reasonable charges of the physician up to the maximum of $1,000 or $10,000 as selected by the policyholder.

A brief review of the entire Blue Shield of Wisconsin program in radiologic benefits is important. Benefits for diagnostic x-ray services associated with surgery or maternity are provided as minimum x-ray benefits for the 350,000 persons covered by Wisconsin Physicians Service. Most of these benefits are provided according to the "A" and "B" fee schedule.

More than 9,000 Wisconsin Physicians Service subscribers have purchased expanded diagnostic x-ray coverage for services in addition to those associated with surgery and maternity. Benefits are paid according to schedule and within a maximum of $50 or $100 as selected by the subscriber.

Another 19,000 of the 350,000 persons covered by WPS have diagnostic x-ray benefits on a "reasonable charge" basis for all x-rays except those associated with dental repair, pre-employment examination, or the purchase of insurance. These are provided under the Special Service contract.

In the area of radiation therapy nearly 18,000 persons already covered under "A" and "B" contracts have purchased a rider providing benefits for the treatment of proven malignancies. Another 27,000 have radiation therapy coverage under Special Service contracts which provide benefits according to the reasonable charges up to the maximum of $1,000 or $10,000. Another 1,500 persons have coverage for radiation therapy through major illness contracts purchased before the advent of the Special Service contract. These benefits are also provided on the basis of reasonable charges of the physician.

DENTAL BENEFITS PLANNED

The Commission has also authorized development of a dental benefit which will be offered as a part of basic coverage to all new groups. The benefit will provide coverage for certain types of oral surgery associated with illness or injury. Details will be worked out in cooperation with a committee of the Wisconsin State Dental Society.

RESEARCH IN INSURANCE

Although a special report of the Charitable Educational and Scientific Foundation of the State Medical Society is being prepared for the delegates, the Commission wishes to direct brief attention to the Blue Shield of Wisconsin commitment of $10,000 to the Foundation for research studies into various phases of surgical and medical insurance for the aged. These funds have been channeled to a school of commerce of the University of Wisconsin through a special grant.

The School of Commerce has undertaken a detailed search of previous studies completed and published which relate to the same topic. An extensive bibliography has been compiled and many previous publications have been abstracted. This is an effort to assure that duplicate studies will not be conducted and to permit the School of Commerce to benefit from information already secured through other research projects.

During the course of 1958 it is anticipated that the study will be expanded to other health organizations and insurance groups.

Through detailed studies of costs, lengths of periods of confinement, types of diagnosis and treatment, and so forth, the school proposes to arrive at conclusions concerning possible ways of providing insurance protection for the aged at reasonable costs.

The foregoing has been a report of varied but closely related activities of the Commission on Medical Care Plans. Society sponsored medical care programs have come a long way in the past 10 years. The future poses many problems, but also many opportunities to demonstrate leadership in medical care protection. The Commission believes that the State Medical Society can not afford to do less than take the broad view and the long outlook if it is to be of greatest service to medicine and the public.

Respectfully submitted,

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REFERENCES: (1) Royer, A., in Welch, H., & Martí-Ibañez, F.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc 1958, p. 783. (2) Waisbren, B. A., & Strelitzer, C. L.: *Arch. Int. Med.* **101**:397, 1958. (3) Koch, R., & Donnell, G.: *California Med.* **87**:31 1957. (4) Roy, T. E.; Collins, A. M.; Craig, G., & Duncan, I. B. R.: *Canad. M. A. J.* **77**:844, 1957. (5) Cooper, M. L., & Keller, H. M. *J. Dis. Child.* **95**:245, 1958. (6) Caswell, H. T., *et al.*: *Surg., Gynec. & Obst.* **106**:1, 1958. (7) Brown, J. V.; Sedwitz, J. L., & Hanner, J. M. *U. S. Armed Forces M. J.*: **9**:161, 1958. (8) Sarason, E. L., & Bauman, S.: *Surg., Gynec. & Obst.* **105**:224, 1957.

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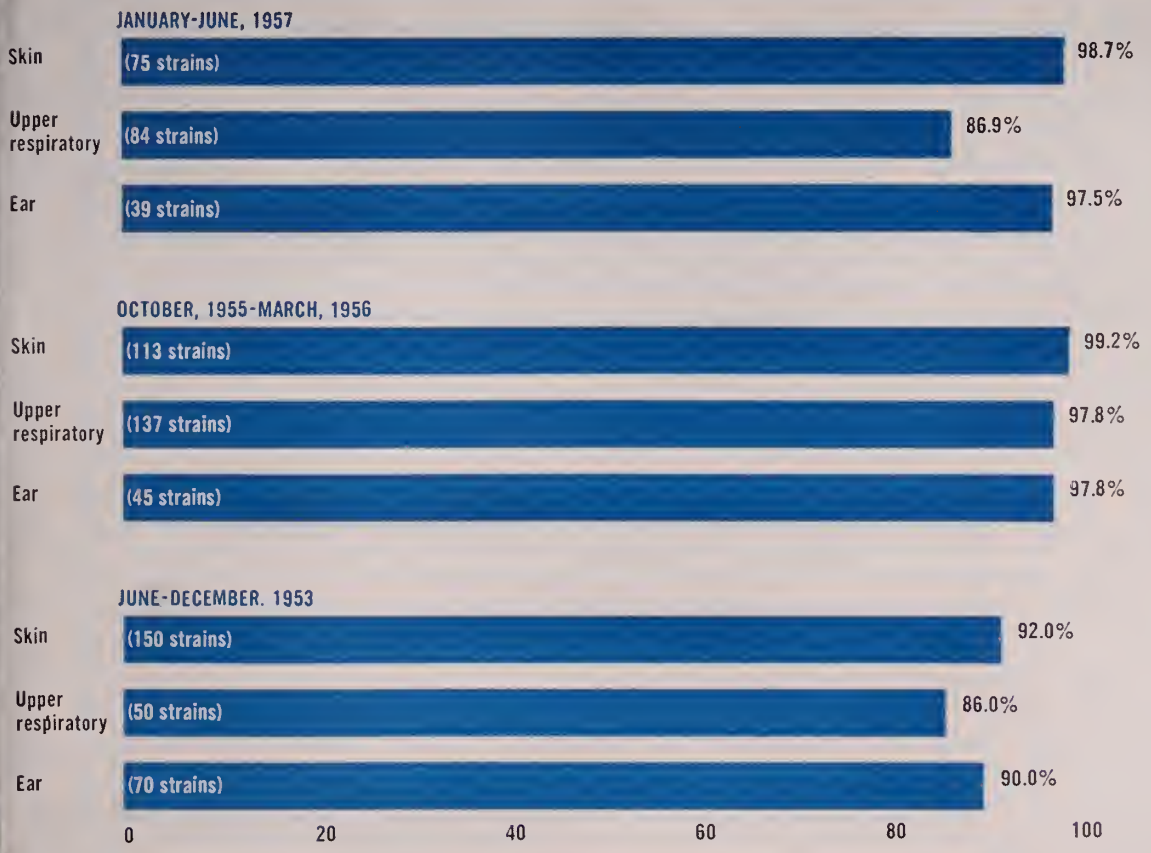

*Adapted from Royer.[1]

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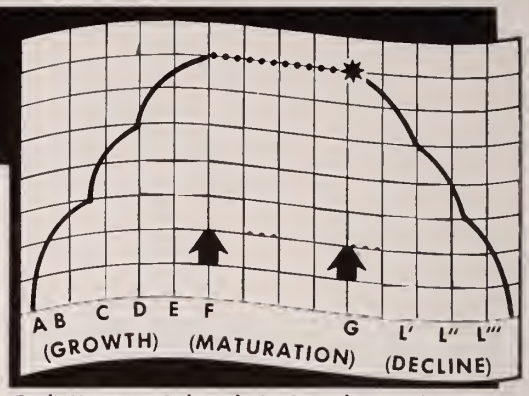
...to postpone the "G" point*...



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*Chappel, C.C., J.A.M.A., 162: 1414, (Dec. 8) 1956

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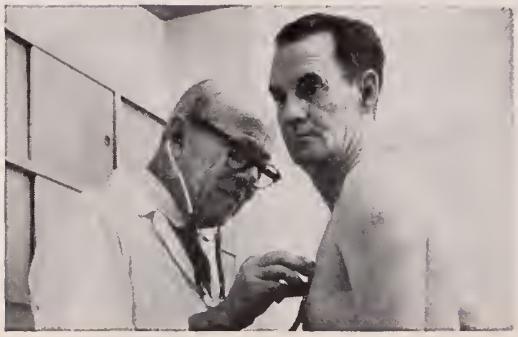

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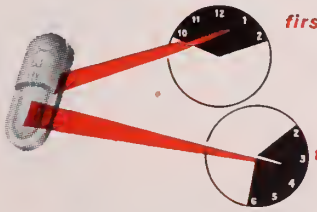

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2. Manuscripts *must be* in the office of the American Congress of Physical Medicine and Rehabilitation, 30 N. Michigan Ave., Chicago 2, not later than March 2, 1959.

3. *Contributions will be accepted from medical students only.*

4. The American Congress of Physical Medicine and Rehabilitation shall have the exclusive right to publish the winning essay in its official journal, the *Archives of Physical Medicine and Rehabilitation.*

5. Manuscripts must not exceed 3000 words (exclusive of headings, references, legends for cuts, tables, etc.), and the number of words should be stated on the title page. An original and one carbon copy of the manuscript must be submitted.

6. The essay must not have been published previously.

7. The winner shall receive a cash award of $100.

8. The winner shall be determined by the Essay Award Committee composed of four members of the American Congress of Physical Medicine and Rehabilitation.

9. All manuscripts will be returned as soon as possible after the name of the winner is announced. The winning manuscript becomes the exclusive property of the American Congress of Physical Medicine and Rehabilitation.

10. The American Congress of Physical Medicine and Rehabilitation reserves the right to make no award if, in the judgment of the Essay Award Committee, no contribution is acceptable. Announcement of the winner will be made at the annual meeting of the American Congress of Physical Medicine and Rehabilitation.

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terns, residents, graduate students in the pre-clinical sciences and graduate students in physical medicine and rehabilitation.

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3. Contributions will be accepted from interns, residents, graduate students in the pre-clinical sciences, and graduate students in physical medicine and rehabilitation.

7. The winner shall receive a cash award of $200.

NOTE!

A summary report of the special session of the House of Delegates of the State Medical Society, who met in Stevens Point in late September, will be found on pages 82–83–84 of the Medical Forum section of The Wisconsin Medical Journal this month. The report covers resolutions and reports, as referred to the House committee for action.

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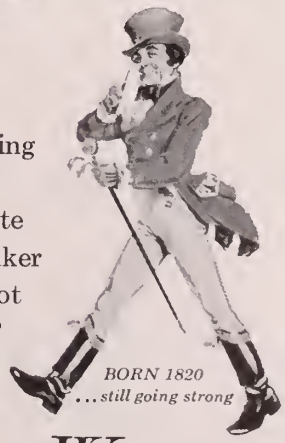

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SCOTCH WHISKY

BLENDED SCOTCH WHISKY, 86.8 PROOF. IMPORTED BY CANADA DRY CORPORATION, NEW YORK, N. Y.

new

PRONOUNCED TAY-O

Tao*

(brand of triacetyloleandomycin with glucosamine)

Capsules / Oral Suspension

designed for effective control of common gram-positive infections

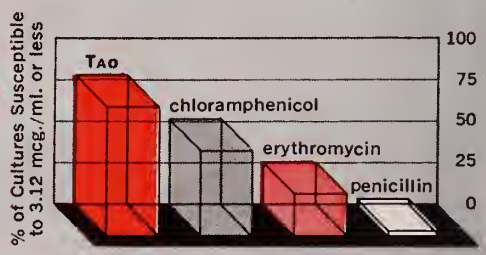
effective . . .

CLINICAL RESULTS	adults	children	all Staph Infections
Cured	172 (80%)	148 (89%)	71 (88%)
Improved	28 (13%)	8 (5%)	7 (9%)
Failure	17 (7%)	11 (6%)	3 (3%)

Types of infecting organisms: The majority of identified etiologic microorganisms were Staph. aureus and Staph. albus. TAO has its greatest usefulness against organisms such as: staphylococci (including strains resistant to other antibiotics), streptococci (beta-hemolytic strains, alpha-hemolytic strains and enterococci), pneumococci, gonococci, Hemophilus influenzae.

even against resistant staph[1,2] . . .

Per cent of "antibiotic-resistant" epidemic staphylococci cultures susceptible to TAO, erythromycin, penicillin and chloramphenicol.[1]



well tolerated . . .

REACTIONS:

(a) adults
Total—9.2% (20 out of 217)
Skin rash—1.4% (3 out of 217)
Gastrointestinal—7.8% (17 out of 217)

(b) children
Total—0.6% (1 out of 167)
Skin rash—none
Gastrointestinal—0.6% (1 out of 167)

There was complete freedom from adverse reactions in 94.5% of all patients. Side effects in the other 5.5% were usually mild and seldom required discontinuance of therapy.

plus . . . stability in gastric acid • rapid, high and sustained blood levels • high urinary concentrations • outstanding palatability in a liquid preparation

Dosage and Administration: Dosage varies according to the severity of the infection. For adults, the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. For children 8 months to 8 years of age, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective. Since TAO is therapeutically stable in gastric acid, it may be administered at any time, without regard to meals.

Supplied: TAO Capsules—250 mg. and 125 mg.; bottles of 60. TAO for Oral Suspension—1.5 Gm.; 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

References: 1. English, A. R., and Fink, F. C.: Antibiotics & Chemother. (Aug.) 1958. 2. English, A. R., and McBride, T. J.: Antibiotics & Chemother. (Aug.) 1958. 3. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy (Aug.) 1958. 4. Celmer, W. D., et al.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 476.

NEW YORK 17, N. Y.

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SCIENCE FOR THE WORLD'S WELL-BEING

*TRADEMARK

now—an antibiotic troche that

STOPS COUGH TOO

The *cough control* provided by homarylamine (a non-narcotic antitussive) approximates that of codeine.

Three antibiotics (bacitracin, tyrothricin, neomycin) act in combination against a wide variety of pathogens—with little danger of side reactions.

The anesthetic-analgesic effect of benzocaine brings *soothing relief* to inflamed tissues of mouth and throat.

PENTAZETS now extend the therapeutic usefulness of convenient troche medication. Each pleasant-tasting PENTAZETS troche acts promptly against the most bothersome aspects of mouth and throat irritations.

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Pentazets®

antitussive—antibiotic—anesthetic—analgesic troches

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DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

Dosage: Three to 5 troches daily for 3 to 5 days.
Supplied: In vials of 12.
PENTAZETS is a trademark of Merck & Co., Inc.

proven effective and unusually well tolerated in over 600 clinical studies

■ does not impair mental efficiency or physical performance ■ relieves both mental and muscular tension ■ does not affect autonomic function

Miltown®

meprobamate (Wallace)

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if you were
in the rheumatoid arthritic's shoes,
Doctor...

wouldn't you want a steroid
with a proved record
of safety and success?

METICORTEN®
prednisone

you can count on rapid relief from pain, swelling and stiffness followed by functional improvement and maintained on an uncomplicated, low-dosage regimen with minimal chance of side effects† and without unexplained weight loss, anorexia, muscle cramps as reported with certain other corticoids†

†Round-table Discussion by Leading Investigators, San Francisco, Calif., June 20, 1958.

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METICORTEN, 1, 2.5 and 5 mg. white tablets.

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Hospital practice of infant feeding

Self-regulated schedules

The newborn may become a feeding problem if the formula is excessive or if he is awakened to be fed forcefully.

The young infant may balk at new food or procedure. The older infant, devoted to his bottle, may resent weaning—it takes a certain readiness for weaning to make the change agreeable. Later, the infant may become somewhat independent and arbitrary—what he enjoyed yesterday he rejects today.

WHOLE MILK FORMULAS

Age Months	Whole Milk Fluid Oz.	Water Oz.	Karo Syrup Tbsp.	Each Feeding Oz.	Number of Feedings in 24 Hours	Total Calories
Birth	10	10	2	3	6	320
1	12	13	3	4	6	532
2	15	13	3	4½	6	480
3	17	9	3	5	5	520
4	20	11	3½	6	5	610
5	23	11	4	6½	5	700
6	26	10	4	7	5	760
7	28	11	3	7½	5	740
8	30	11	2½	8	5	750
10	32	9	2	8	5	760
12	32	9	0	8	5	640

EVAPORATED MILK FORMULAS

Age Months	Evaporated Milk Fluid Oz.	Water Oz.	Karo Syrup Tbsp.	Each Feeding Oz.	Number of Feedings in 24 Hours	Total Calories
Birth	6	12	2	3	6	380
1	8	16	3	4	6	532
2	9	14	3	4½	5	576
3	10	15	3½	5	5	650
4	12	18	4	6	5	768
5	12	21	4	6½	5	768
6	13	22	4	7	5	812
7	14	21	3	7	5	796
8	15	20	2	7	5	780
10	16	16	1	8	4	764
12	16	16	0	8	4	704

When a feeding problem is in the making, sensible decorum will solve it. Nature invites infant feeding cooperation through hunger. If hunger is appeased on demand rather than by clock there will be fewer problems—the baby is the best judge of when he wants food and how much.

Feeding must be adapted to the infant individually to make it a pleasurable experience. This is the current objective in successful infant feeding formulated for normal infants in the charts below:

ADVANTAGES OF KARO® SYRUP IN INFANT FEEDING

Composition: Karo Syrup is a superior dextrin-maltose-dextrose mixture because the dextrins are non-fermentable and the maltose is rapidly transformed into dextrose which requires no digestion.

Concentration: Volume for volume Karo Syrup furnishes twice as many calories as similar milk modifiers in powdered form.

Purity: Karo Syrup is processed at sterilizing temperatures, sealed for complete hygienic protection and devoid of pathogenic organisms.

Low Cost: Karo Syrup costs 1/5 as much as expensive milk modifiers and is available at all food stores.

Free to Physicians—Book of Infant Feeding Formulas with convenient schedule pads. Write: Karo Infant Feeding Guide, Box 280, New York 46, N. Y.

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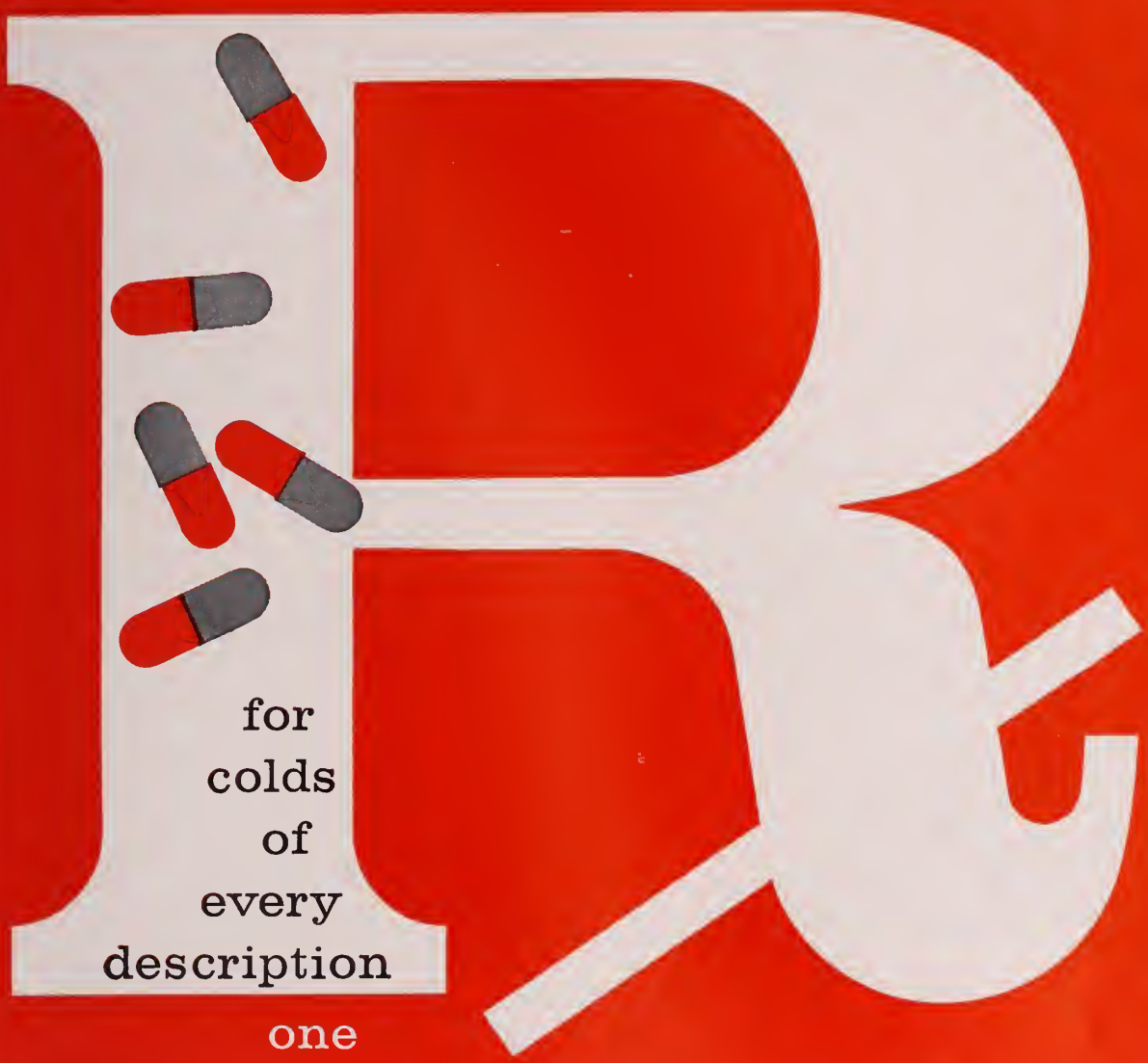

for colds of every description

one inclusive prescription

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Each CORICIDIN FORTE Capsule provides
CHLOR-TRIMETON® Maleate
(chlorprophenpyridamine maleate) . . . . . 4 mg.
Salicylamide . . . . . 0.19 Gm.
Phenacetin . . . . . 0.13 Gm.
Caffeine . . . . . 30 mg.
Ascorbic acid . . . . . 50 mg.
Methamphetamine hydrochloride . . . . . 1.25 mg.

Dosage—1 capsule q. 4-6.

Supplied—Bottles of 100 and 1000.

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Provides therapeutic quantities of all known hematinic factors

Potent 'Trinsicon' offers complete and convenient anemia therapy plus maximum absorption and tolerance. Just two Pulvules 'Trinsicon' daily produce a standard response in the average uncomplicated case of pernicious anemia (and related megaloblastic anemias) and provide at least an average dose of iron for hypochromic anemias, including nutritional deficiency types. The intrinsic factor in the 'Trinsicon' formula enhances (never inhibits) vitamin B_{12} absorption.

Available in bottles of 60 and 500.

*'Trinsicon' (Hematinic Concentrate with Intrinsic Factor, Lilly)

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when psychic symptoms distort the picture

Dartal helps the patient reintegrate his mental processes

In everyday office practice as well as under hospital conditions Dartal is consistent in its effects as few tranquilizers are.

Dartal promotes emotional balance

Dartal effectively decreases or relieves emotional hyperactivity and psychomotor excitement.

Dartal is unusually safe

At a recent symposium, leading hepatologists* concluded that Dartal is not icterogenic or hepatotoxic.

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One 2-mg. tablet q.i.d. or one 5-mg. tablet t.i.d. in neuroses; one 10-mg. tablet t.i.d. in psychoses.

a superior psychochemical
for the management of both major and minor emotional disturbances

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dihydrochloride brand of thiopropazate dihydrochloride

SEARLE

*A Symposium on the Pharmacologic Effects of Dartal on the Liver, Chicago, Searle Research Laboratories, Feb. 7, 1958.

The Achievements of

Arist

...in Skin Diseases: In a study of 26 patients with severe dermatoses, ARISTOCORT was proved to have potent anti-inflammatory and antipruritic properties, even at a dosage only ⅔ that of prednisone[1]... Striking affinity for skin and tremendous potency in controlling skin disease, including 50 cases of psoriasis, of which over 60% were reported as *markedly improved*[2]...absence of serious side effects specifically noted.[1,2,3]

...in Rheumatoid Arthritis: Impressive therapeutic effect in most cases of a group of 89 patients[4]... 6 mg. of ARISTOCORT corresponded in effect to 10 mg. of prednisone daily (in addition, gastric ulcer which developed during prednisone therapy in 2 cases disappeared during ARISTOCORT therapy).[5]

1. Rein, C. R., Fleischmajer, R., and Rosenthal, A. L.: J. A. M. A. *165*:1821, (Dec 7) 1957.
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12. Cooke, R. A.: Personal Communication.
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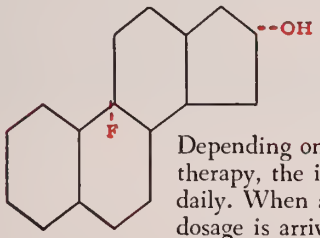
...in Respiratory Allergies: "Good to excellent" results in 29 of 30 patients with chronic intractable bronchial asthma at an average daily dosage of only 7 mg.[6]... Average dosage of 6 mg. daily to control asthma and 2 to 6 mg. to control allergic rhinitis in a group of 42 patients, with an actual reduction of blood pressure in 12 of these.[7]

...in Other Conditions: Two failures, 4 partial remissions and 8 cases with complete disappearance of abnormal chemical findings lead to characterization of ARISTOCORT as possibly the most desirable steroid to date in treatment of the nephrotic syndrome.[8,9]... Prompt decrease in the cyanosis and dyspnea of pulmonary emphysema and fibrosis, with marked improvement in patients refractory to prednisone.[10,11,12]... Favorable response reported for 25 of 28 cases of disseminated lupus erythematosus.[13]



Depending on the acuteness and severity of the disease under therapy, the initial dosage of ARISTOCORT is usually from 8 to 20 mg. daily. When acute manifestations have subsided, maintenance dosage is arrived at gradually, usually by reducing the total daily dosage 2 mg. every 3 days until the smallest dosage has been reached which will suppress symptoms.

Comparative studies of patients changed to ARISTOCORT from prednisone indicate a dosage of ARISTOCORT lower by about ⅓ in rheumatoid arthritis, by ⅓ in allergic rhinitis and bronchial asthma, and by ⅓ to ½ in inflammatory and allergic skin diseases. With ARISTOCORT, no precautions are necessary in regard to dietary restriction of sodium or supplementation with potassium.

ARISTOCORT is available in 2 mg. scored tablets (pink), bottles of 30; and 4 mg. scored tablets (white), bottles of 30 and 100.

Lederle LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

A Special Invitation . . .

for you to participate in the

WISCONSIN PHYSICIANS' PHOTOGRAPHY EXHIBIT!

For all members of the State Medical Society, the exhibit is a project of the Charitable, Educational and Scientific Foundation.

No entry fee, and each doctor may enter as many pictures as he desires. For exhibit rules, write Box 1109, Madison 1.

Entries will be received at the Society office after Feb. 15. The final deadline is April 1.

Pictures will be displayed at the Annual Meeting of the Society in May.

Prizes will be awarded at the Annual Dinner.

All physicians are invited to submit pictures they have taken in the following classes:

CLASS A—"Physicians at Work"

CLASS B—"Physicians in Research and Teaching"

CLASS C—"Physicians and History"

CLASS D—"Physicians in Public Service"

CLASS E—"Physicians at Play"

BE SURE to notify the Society if you wish to enter!

Editorial Comment

IS THE BABY BOOM ENDING?

Although the number of births in the United States still exceeds 300,000 a month, the total for the first quarter of this year was some 7,000 below last year. This small decline in the number of births has occurred less than nine months after the decline in the number of marriages. These two declines suggest but do not prove that the end of the baby boom is in sight. Because of the comparatively small number of births during the 1930's, the number of youths attaining marriageable age continues to be fewer than can be expected during the 1960's.

Doubtless the small decline in the number of births during the first quarter of 1958 and the earlier decline in the marriages is due in some measure to the business recession. To that extent, an increase in the number of both the births and marriages will depend upon improvement in business conditions. Forecasting business developments is somewhat beyond the scope of THE JOURNAL. We submit, however, that these recent declines in births and marriages should make one hesitate about predicting a population explosion in the United States as has been frequently predicted in recent years for the world as a whole. Much will depend on the number of second, third, and fourth order births; the publication of birth-order data lags two or more years. At the very least, until the trends of births and marriages become a little clearer we cannot conclude with any degree of firmness whether the present plateau is a prelude to a considerable decline or a mere interval in an irregular rise in births and marriages.—*Reprinted from J.A.M.A., Vol. 167, No. 10, July 5, 1958.*

CORRESPONDENCE

TO ALL WISCONSIN PHYSICIANS:

Many of you occasionally render medical service to members of the Armed Forces, most often in emergency conditions. This letter is written to help you in collecting your fees for these services from the government.

If the patient is in the Army send your bill to: U.S. Army Dispensary (5012–01), Fort Sheridan, Illinois.

If the patient is a member of a service other than Army send your bill to the nearest of the following Air Force Medical facilities:

(1) Commander
343rd USAF Dispensary
Duluth Municipal Airport
Duluth, Minnesota

(2) Commander
327th USAF Dispensary
Truax Field
Madison, Wisconsin

(3) Commander
56th USAF Dispensary
O'Hare International Airport
Park Ridge, Illinois

Your bill must include the following information about the patient:

(1) Name
(2) Rank
(3) Serial Number
(4) Organization i.e. "his outfit"
(5) Duty Status—for example "on leave", on pass, on temporary duty away from his station, etc.

The bill must be itemized to include:

(1) Diagnosis
(2) Specific dates of treatment including itemized charges for medicines, procedures and treatments on each date.
(3) If an injury is involved, the cause of the injury is desired.

Please note that elective medical care for military personnel by civilian physicians is not authorized. Such care can and must be accomplished by military installations.

By following this procedure your bills will be paid more promptly and without further to and fro inquiries between your office and the military installations involved.

JAMES A. STUART M.D.
Capt. USAF (MC)
Division Surgeon (37th ADiv)
Truax Field
Madison, Wisconsin

Functional and Organic Control

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Gastrointestinal
Irritability and Tension

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Potent ANTISECRETORY • ANTICHOLINERGIC • SEDATIVE

Each tablet contains:

Monodral bromide.....**5 mg.**
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PROVIDES:
Dependable control of hyperacidity and hypermotility. Spasmolysis. Prompt and prolonged pain relief and tranquillity.

DOSE:
Peptic ulcer, 1 or 2 tablets three or four times daily. Other gastrointestinal disorders, 1 tablet three or four times daily.

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Monodral (brand of penthienate), Mebaral (brand of mephobarbital), and Creamalin, trademarks reg. U.S. Pat. Off.

OFFICIAL CALL FOR

Scientific Exhibits

★

1959 ANNUAL MEETING MILWAUKEE MAY 5–6–7

★

THE Council on Scientific Work is desirous of knowing which members of the State Medical Society are interested in presenting scientific exhibits in connection with the 1959 Annual Meeting. The exhibits will be located in Bruce Hall of the Milwaukee Auditorium.

To facilitate arrangements for the proper location of the scientific exhibits, individuals and organizations desiring space at the 1959 meeting are requested to file an application BEFORE JANUARY 1, giving a full description of the exhibit, the amount of space required, and the basic equipment which will be needed.

In-state exhibitors will have the following facilities provided by the State Medical Society: Velour booth, electrical connection, shelving or tables, and identifying sign.

The exhibitor must furnish: Transportation costs of exhibit, special radiologic viewing boxes, special chrome furniture or rugs, special lighting equipment, and half the cost of any drapes rented (rented through Badger Flag and Decorating Company at time exhibit is installed).

Booths for scientific exhibits will have dark maroon velour background, 8′ in height, and *8′ velour side dividers (not the 3′ dividers shown on the illustration).*

No exhibit may exceed a height of 7′ from the floor.

Counters (3′ high and 20″ wide) or tables (30″ high and 3′ wide) are available for viewboxes or displays to be raised above floor level.

Spaces can be allocated in 10′ units.

Those interested in providing an exhibit are required to file an application and a full description of the exhibit by January 1. *No applications can be accepted after that date.* Address your communications to Roy B. Larsen, M. D., director of scientific exhibits, c/o The State Medical Society of Wisconsin, Box 1109, Madison 1, Wis.

APPLICATION

For Participation in the Scientific Exhibit

1959 ANNUAL MEETING **MILWAUKEE** **MAY 5-6-7**

Fill Out and Mail to:

ROY B. LARSEN, M. D., *Director of Scientific Exhibits*
c/o State Medical Society of Wisconsin
Box 1109
Madison 1, Wisconsin

---

1. Title of exhibit: _____

2. Description of exhibit (attach 200-word description to this blank): _____

3. The standard booth is 10′ wide and 9′ deep. What is the *minimum* space your display will require? 10′ 20′ 30′ (Circle One)
(Space is scarce so do not request more than is necessary).

> In figuring space, bear in mind you can use up to 8′ on each side in addition to back wall space of 10′ (less than 8′ if your display fills the entire back wall width).

4. Will radiologic viewing boxes be used? If so, will you furnish them? _____
(The State Medical Society does not have equipment of this character available).

5. Name of exhibitor: _____

6. Name of institution cooperating in exhibit: _____

ANNUAL MEETING FEATURES: MAY 5–6–7, 1959

TUESDAY: General Practice Day *(Category 1 credit for Academy members!)*

WEDNESDAY: Special Programs on Internal Medicine, Obstetrics and Gynecology, Psychiatry, Radiology, and Special Surgical Problems.

THURSDAY: Special Programs on Anesthesia, Dermatology, Ophthalmology and Otolaryngology, Pediatrics, and Surgery.

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both cause and fear of
ANGINA ATTACKS

proven safety for long-term use

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"In diagnosis and treatment [of cardiovascular diseases] . . . the physician must deal with both the emotional and physical components of the problem simultaneously."[1]

The addition of Miltown to PETN, as in Miltrate,"...appears to be more effective than [PETN] alone in the control of coronary insufficiency and angina pectoris."[2]

Miltrate is recommended *for prevention* of angina attacks, *not for relief* of acute attacks.

Supplied: Bottles of 50 tablets.
Each tablet contains: 200 mg. Miltown + 10 mg. pentaerythritol tetranitrate.
Usual dosage: 1 or 2 tablets q.i.d. *before meals* and at bedtime.
Dosage should be individualized. *For clinical supply and literature, write Dept. 60B*

1. *Friedlander, H. S.: The role of ataraxics in cardiology. Am. J. Card.* 1:395, *March 1958.*
2. *Shapiro, S.: Observations on the use of meprobamate in cardiovascular disorders. Angiology* 8:504, *Dec. 1957.*

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CAPSULES
(black and white)
250 mg., 125 mg.

ORAL SUSPENSION
(orange-flavored)
125 mg. per tsp. (5 cc.), 2 oz. bottle

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Proven in research

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antibacterial plus added protection against monilial superinfection

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For relief of symptoms and malaise of the common cold and prevention of secondary complications

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REFERENCES: 1. Carlozzi, M.: Ant. Med. & Clin. Therapy 5:146 (Feb.) 1958. 2. Welch, H.; Wright, W. W., and Staffa, A. W.: Ant. Med. & Clin. Therapy 5:52 (Jan.) 1958. 3. Marlow, A. A., and Bartlett, G. R.: Glucosamine and Leukemia. Proc. Soc. Exp. Biol. & Med. 84:41, 1953. 4. Shalowitz, M.: Clin. Rev. 1:25 (April) 1958. 5. Nathan, L. A.: Arch. Pediat. 75:251 (June) 1958. 6. Cornbleet, T.; Chesrow, E., and Barsky, S.: Ant. Med. & Clin. Therapy 5:328 (May) 1958. 7. Stone, M. L.; Sedlis, A., Bamford, J., and Bradley, W.: Ant. Med. & Clin. Therapy 5:322 (May) 1958. 8. Harris, H.: Clin. Rev. 1:15 (July) 1958.

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Unprecedented Low Dosage—Less sulfa for the kidney to cope with . . . yet fully effective. A single daily dose of 0.5 to 1.0 Gm. maintains higher plasma levels than 4 to 6 Gm. daily of other sulfonamides—a notable asset in prolonged therapy.[2]

Dosage: The recommended adult dose is 1 Gm. (2 tablets) the first day, followed by 0.5 Gm. (1 tablet) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours.

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references:

1 Grieble, H.G., and Jackson, G.G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958

2. Editorial: *New England J. Med.* 258:48-49, 1958.

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Vitamin B-2	2.5 mg.
Vitamin B-6	1 mg.
Vitamin B-12 Activity	3 mcg.
Panthenol	5 mg.
Nicotinamide	20 mg.
Folic Acid	0.1 mg.
Biotin	30 mcg.
Rutin	12 mg.
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Fluorine	0.1 mg.
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Society Proceedings*

Clark

An immunization program to offer protection against diphtheria, whooping cough, tetanus and smallpox is being sponsored by the Clark County Medical Society and County Health Committee. Eleven clinics have been set up in the county for the purpose of giving these shots to pre-school and school-age children.

Fond du Lac

The Fond du Lac County Medical Society met September 18 at the Elks Club in Fond du Lac for a business meeting. During the session the controversy between the State Medical Society and Milwaukee County Medical Society relating to their insurance plans was discussed. A motion was made and unanimously carried that the Fond du Lac Delegate to the House of Delegates of the State Medical Society vote in favor of the State Society's insurance plan, known as Wisconsin Physicians Service, at a special session of the House on September 27–28 at Stevens Point; and that if no amicable solution could be achieved at this special session, that the Fond du Lac county physicians exclude the promotion in their county of the insurance plan of the Milwaukee County Medical Society known as Surgical Care. A report on negotiations with County Welfare Society regarding the fee schedule was also given.

Another item on the agenda was the election of officers. Those chosen for the term beginning January 1, 1959, were:

E. W. Vetter, M.D.—President
H. R. Sharpe, Jr., M.D.—Vice-President
R. W. Schroeder, M.D.—Secretary-Treasurer

Drs. D. J. Twohig, Jr., and *R. S. Pelton* were named as delegate and alternate delegate, respectively, with the duties of their offices commencing immediately.

Marathon

Forty-one members of the Marathon County Medical Society met September 25 at the Wausau Club in Wausau.

Guest speaker at the meeting was Mr. Roger Maas, Ph.D., who addressed the society on "Hearing and the Relation of Hearing Loss to Industrial Noise."

* Physicians whose names are printed in italics are members of the Society.

Milwaukee Oto-Ophthalmic Society Meetings 1958–1959

Meetings of the Milwaukee Oto-Ophthalmic Society for 1958–1959 will be held at the University Club with a social hour at 6:00 p.m., dinner at 7:00 p.m. and a scientific meeting at 8:00 p.m. The schedule of meetings is as follows:

November 25, 1958: Symposium. Visual Acuity and Hearing Requirements as related to Motor Vehicle Accident Prevention. Panelists, Mr. John W. Thompson, Director Driver License Division, State of Wisconsin, Madison, Chief of Police Howard O. Johnson, Milwaukee, Mr. James O. Kelley, Executive Secretary, Milwaukee County Medical Society, *Dr. George Nadeau*, M.D., Chairman Division on Visual and Hearing Defects of the State Medical Society, *Dr. M. S. Fox*, M.D., Member, Committee on Conservation of Hearing, A.A.O.O.; Walter Mattison, Milwaukee City Attorney.

December 23, 1958: Guest Speaker: Dr. Max S. Sadove, M.D., Professor Surgery (Anesthesia) Head Division Anesthesia, University of Illinois Research and Educational Hospitals, Chicago, Illinois. Subject: Anesthesia Problems in Ophthalmology and Otolaryngology.

January 27, 1959: Guest Speaker: Dr. Robert W. Hollenhorst, M.D., Consultant in Ophthalmology, Mayo Clinic, Assistant Professor Ophthalmology Graduate School University of Minnesota, Mayo Foundation, Head Section of Perimetry and Neuro-ophthalmology Home Study Course American Academy Ophthalmology, and Chairman Section Ophthalmology Minnesota State Medical Association. Subject: Ocular Manifestations of Intracranial Vascular Diseases.

February 24, 1959: Guest Speaker: Dr. Charles E. Iliff, M.D., Professor of Ophthalmology, Johns Hopkins University Medical School, Baltimore, Maryland. Subject: Ptosis Surgery.

March 24, 1959: Guest Speaker: Dr. George Schambaugh, Jr., M.D., Professor and Head of Department Otolaryngology, Northwestern University Medical School, Chairman Department of Otolaryngology, Chicago Wesley Memorial Hospital. Subject: Encounters with the Facial Nerve by the Otolaryngolic Surgeon.

April 28, 1959: Guest Speaker: Dr. Jack Guyton, M.D., Chief Department Ophthalmology, Henry Ford Hospital, Detroit, Michigan. Subject: Ocular Surgery.

May 26, 1959: Annual Meeting to be announced.

Outagamie

Dr. William Young, University Hospitals, Madison, spoke at the September 18 meeting of the Outagamie County Medical Society held at the Elks Club in Appleton Following Doctor Young's talk on open-heart surgery a report on the tissue committee was given by *Dr. James Erchul*. In addition to this, *Dr. Guy Carlson* discussed the special meeting of the House of Delegates.

Pierce–St. Croix

An afternoon meeting was held by the Pierce–St. Croix County Medical Society at *Dr. H. J. Laney's* cottage on September 16.

The society's October meeting was held on the 14th at the Limberg Clinic in Glenwood City.

Rock

An address on chest diseases and present problems of tuberculosis control was delivered by *Dr. James Wilkie* of Madison at the September 23 meeting of the Rock County Medical Society. The group met in the Pinehurst Sanatorium, Janesville.

Following the talk a business meeting was held, during which four new members of the society were introduced and a delegate's report was given.

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Conference Headquarters—Roosevelt Hotel—March 2, 3, 4, 5, 1959

GUEST SPEAKERS

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Otto H. Janton, M. D., Philadelphia, Penn. CARDIOLOGY
Carl T. Nelson, M. D., New York, N. Y. DERMATOLOGY
Clifford I. Barborka, M. D., Chicago, Ill. GASTROENTEROLOGY
Malcom E. Phelps, M. D., El Reno, Okla. GENERAL PRACTICE
Keith P. Russell, M. D., Los Angeles, Calif. GYNECOLOGY
William Dameshek, M. D., Boston, Mass. INTERNAL MEDICINE
Howard P. Rome, M. D., Rochester, Minn. NEUROPSYCHIATRY
R. Gordon Douglas, M. D., New York, N. Y. OBSTETRICS
Maynard C. Wheeler, M.D., New York, N. Y. OPHTHALMOLOGY
Lenox D. Baker, M. D., Durham, N. C. ORTHOPEDIC SURGERY
Ben H. Senturia, M. D., St. Louis, Mo. OTOLARYNGOLOGY
Francis Bayless, M. D., Cleveland, Ohio PATHOLOGY
Lee F. Hill, M. D., Des Moines, Iowa PEDIATRICS
Roy R. Greening, M. D., Philadelphia, Penn. RADIOLOGY
John M. Dorsey, M. D., Evanston, Ill. SURGERY
F. Henry Ellis, Jr., M. D., Rochester, Minn. SURGERY
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Leaving March 6 from New Orleans and returning March 21, 1959.

For information concerning the Assembly meeting and the tour write Secretary, Room 103, 1430 Tulane Avenue, New Orleans 12, La.

Sauk

The Sauk County Medical Society met September 9 at the Warren Hotel in Baraboo to hear Dr. Josef Preizler, epidemiologist at the State Board of Health, lecture on "Epidemiology of Salmonellosis." Later in the program Miss Elizabeth Terry, Sauk County Public Health Nurse, presented her annual report and recommendations for the Public Program for the ensuing year.

Nineteen members and four guests were present.

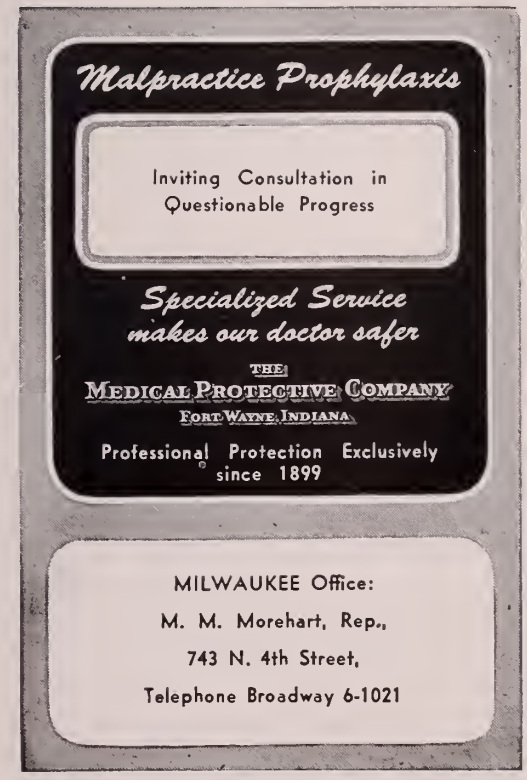
Wisconsin Orthopaedic Section

At a recent meeting of the Orthopaedic Section of the State Medical Society, the following physicians were elected to office for a period of two years:

President: *James W. Nellen*, Green Bay
Secretary-Treasurer: *J. E. Kaufman*, Green Bay
Delegate: *Paul K. Odland*, Janesville
Alternate Delegate: *Marvin W. Nelson*, Racine

Wisconsin Society of Internal Medicine

Members attending the annual meeting of the Wisconsin Society of Internal Medicine at Mercy Hospital, Janesville, September 20, elected *Dr. Paul G. LaBissoniere*, Milwaukee, president-elect. *Dr. J. LeRoy Sims*, Madison, was installed as president, succeeding *Dr. Robin N. Allin*, also of Madison.



Officers and council members of the Wisconsin Society of Internal Medicine for 1958–1959 posed for pictures after the business portion of the Society's Annual Meeting held at Mercy Hospital, Janesville, September 20. Left to right are: Drs. Paul G. LaBissoniere, Milwaukee, president-elect; William L. Coffey, Jr., Milwaukee, director; Robert L. Gilbert, La Crosse, secretary–treasurer; Herbert M. Snodgrass, Janesville, director; and J. LeRoy Sims, Madison, president. (Not pictured: Drs. Leslie G. Kindschi, Monroe, director; and Warren K. Simmons, Rhinelander, director.)

Dr. Robert L. Gilbert, La Crosse, was elected secretary-treasurer. *Dr. William L. Coffey, Jr.*, Milwaukee, was elected to a three-year term on the board of directors. Other directors are *Drs. Leslie G. Kindschi*, Monroe, *Warren K. Simmons*, Rhinelander, and *Herbert M. Snodgrass*, Janesville.

Nearly 100 internists from throughout the state attended the meeting.

The featured speaker during the annual meeting program was *Dr. William S. Middleton*, chief of medicine and surgery, Veterans Administration, Washington, D. C. Doctor Middleton gave the first Middleton lecture, a lecture series named for him and inaugurated this year in recognition of his outstanding contributions to the field of internal medicine. The series will become a permanent part of the Society's annual meeting program. Before accepting his present position, Doctor Middleton was dean of the University of Wisconsin Medical School from 1935 to 1955.

Papers presented during the scientific session of the Society's meeting included: "Chemotherapy of Hypercholesterolemia," by *Dr. W. B. Parsons, Jr.*, Madison; "Hypersensitivity Angiitis of the Lung with Associated Moniliasis," by *Dr. S. E. Sivertson*, La Crosse; "Intrahepatic Obstructive Jaundice," by *Dr. J. LeRoy Sims*, Madison; "Disseminated Lupus Erythematosus with Diabetes," by *Dr. Robin N. Allin*, Madison.

A clinical pathological conference was presented by *Drs. G. E. Gutmann*, Janesville; *Leslie G. Kindschi*, Monroe, and *M. B. Llewellyn*, Janesville.

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Available forms:

1. Panalba Capsules, bottles of 16 and 100 capsules. Each capsule contains:

Panmycin phosphate (tetracycline phosphate complex) equivalent to tetracycline hydrochloride	250 mg.
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Panmycin (tetracycline) equivalent to tetracycline hydrochloride	125 mg.
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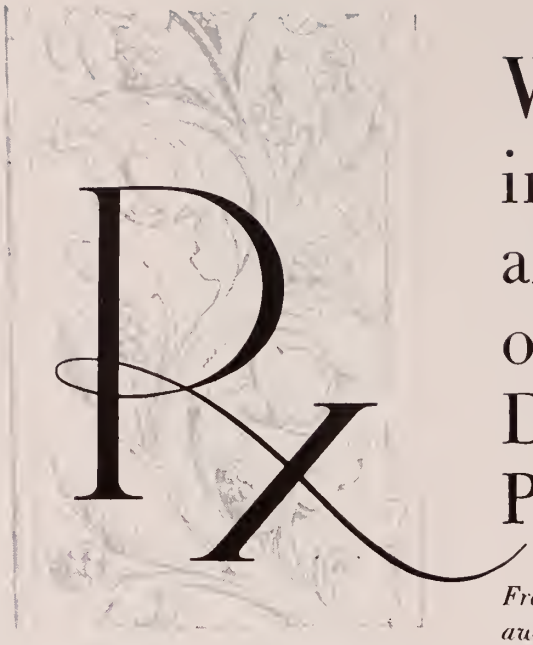
For the treatment of moderately acute infections in infants and children, the recommended dosage is 1 teaspoonful per 15 to 20 lbs. of body weight per day, administered in 2 to 4 equal doses. Severe or prolonged infections require higher doses. Dosage for adults is 2 to 4 teaspoonfuls 3 or 4 times daily, depending on the type and severity of the infection.



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A glass of Sherry at mealtime stimulates the jaded appetite, serves as a tonic and aids the digestion. As a postprandial or between-meals' beverage, a glass of Port has been warmly recommended for the sick and enfeebled.

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- in pregnancy—pre- and postoperative states—gastroenteritis—alcoholism—cancer and chronic diseases
- control is achieved with low dosage—usually 15 to 20 mg. daily—and often within a half hour after the first oral dose

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. . .for immediate control of severe vomiting:

Ampuls, 2 cc. (5 mg./cc.)

NEW: Multiple dose vials, 10 cc. (5 mg./cc.)

—always carry one in your bag

Also available:

Tablets, 5, 10 and 25 mg., in bottles of 50 and 500.

Spansule† *capsules,* 10, 15 and 30 mg., in bottles of 30 and 250.

Suppositories, 5 and 25 mg., in boxes of 6.

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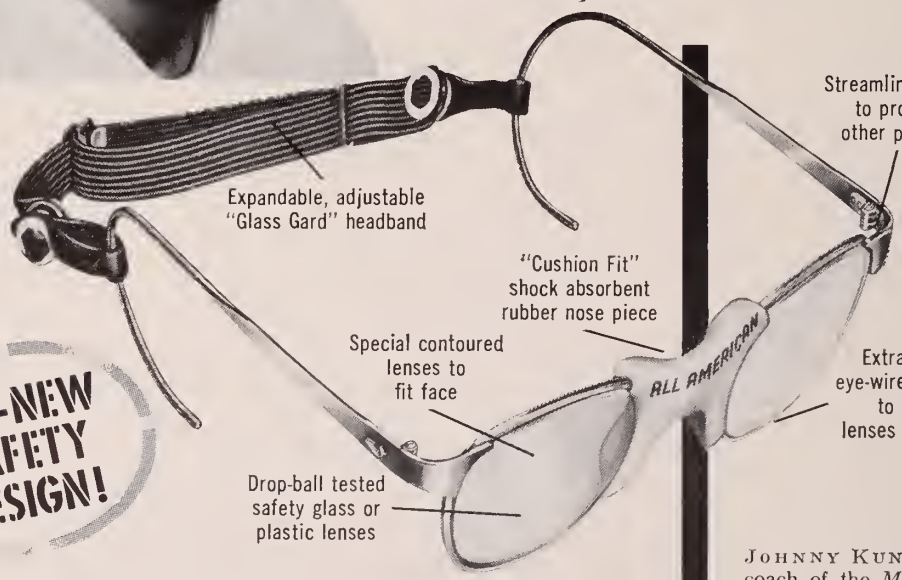

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News Items and Personals*

Clinic Celebrates Anniversary

Grandview Clinic, La Crosse, recently celebrated its 10th anniversary with a clinical meeting. Physicians from the surrounding area attended to hear papers presented by members of the clinic staff.

Grandview Clinic originated with a consolidation of the practices of two of its present members and at the present time consists of nine physicians and one dentist.

The clinical meeting was followed by a reception and dinner at the La Crosse Country Club.

Oconomowoc Gets New Doctor

A general practitioner, Dr. Gregory L. Gallo, has begun practice in Oconomowoc. The doctor grew up in Kenosha and received his medical degree from the University of Wisconsin in 1957. Following this he served a rotating internship at Parkland Memorial Hospital, Dallas, Texas, and recently completed a postgraduate course in anesthesia at Madison.

Physician Leaves Plum City

In August *Dr. Peter Foderick* moved to Rochester, Minnesota, to establish a medical practice. He had been located in Plum City for the past two years.

Green Bay Doctors Affiliate

Announcement was made recently that *Drs. F. J. Gosin* and *T. E. Lynn* are now associated in practice and have formed the Gosin–Lynn Clinic. Doctor Lynn's practice is primarily devoted to general and chest surgery, while Doctor Gosin has a general practice.

Before settling in Green Bay, Doctor Lynn graduated from Northwestern University, interned at Mary Hitchcock Hospital, and spent five and one-half years in postgraduate surgical training. He is a diplomate of the National Board and has been certified by the American Board of Surgery. He has had a number of articles published in surgical journals.

Dr. Ambrose Takes Office

Elections were recently held for officers of the Walworth County Cancer Association. At the meeting in Elkhorn on September 9 *Dr. Stephen H. Ambrose*, general practitioner from Whitewater, was chosen president of the board of directors.

Allergists Hear Dr. Lipman

A paper entitled, "The Clinical Evaluation of Parabromdylamine Maleate (Dimetane, a New Antihistaminic Drug)," was presented by *Dr. William H. Lipman* of Kenosha at the International Congress of Allergists in Paris, France, on October 21. Doctor Lipman is one of a group of American physicians who has done clinical research on this particular new drug.

After the Paris session the doctors participated in allergy symposia in a number of European cities. Doctor Lipman also participated in several of these sessions.

He delivered papers before the International Society in 1951 and to a similar group in Rio de Janeiro, Brazil, in 1955.

Dr. Marshall Moves Offices

Dr. Wallace Marshall has moved his offices from Two Rivers, where he has practiced for the past nine years, to Watertown. He stated that he has made this change to be closer to the medical centers in both Madison and Milwaukee.

Following his relocation, Doctor Marshall attended the 15th annual meeting of the American Medical Writers Association held in Chicago September 26. During the meeting he served as moderator at a section devoted to non-medical writing by members of the Association.

Besides having written more than 200 medical articles, Doctor Marshall is the author of a book, "Essentials of Medical Research."

Hess Clinic Has New Staff Member

Staff officers of the Hess Clinic have announced the affiliation of Dr. Jack Strong, a general practitioner. Doctor Strong was a member of the Macon Hospital staff of Macon, Georgia, as a resident physician in general practice before joining the Clinic. Prior to that he graduated from the University of Illinois, served his internship at the Sacramento County Hospital, Sacramento, California, and served as a captain in the Army medical corps in Bordeaux, France.

Doctor Gundersen Speaks at Insurance Meeting

Dr. Gunnar Gundersen, La Crosse, president of the American Medical Association, spoke on socio-economic medicine October 23 at the sixty-seventh annual meeting of the Association of Life Insurance Medical Directors of America at Hartford, Conn.

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* Physicians whose names are printed in italics are members of the Society.

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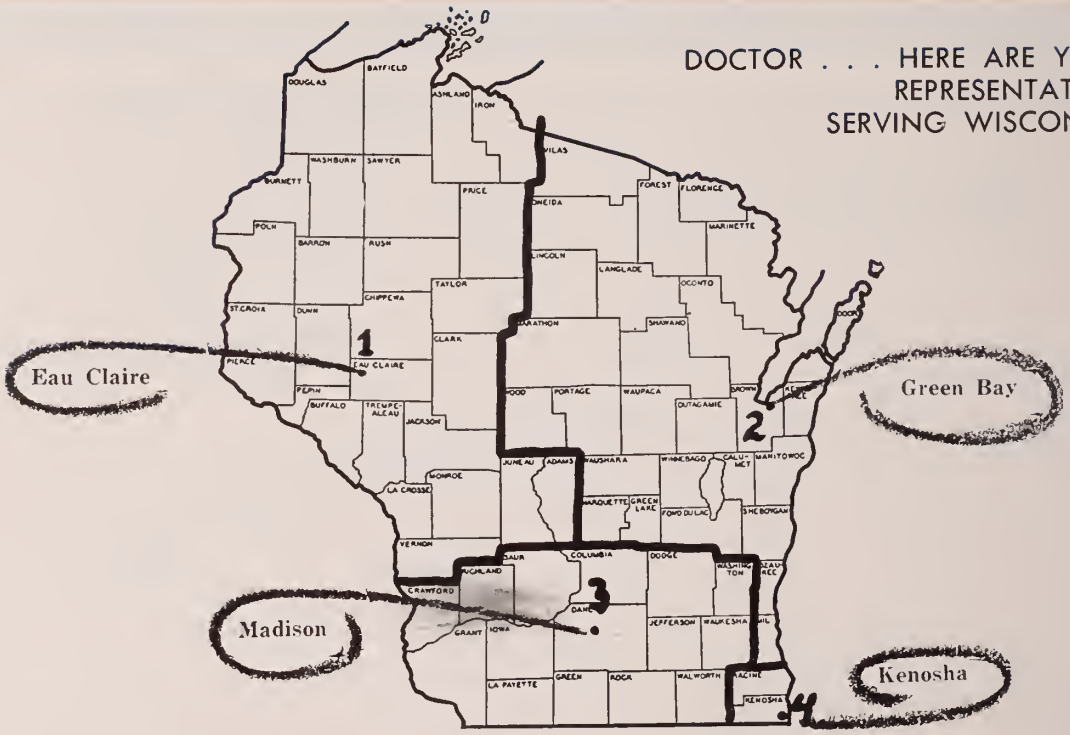

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Dr. Guenther Observes 33rd Year at Campbellsport

At a meeting held at the Bauer Hotel in September, the Campbellsport Lions Club honored *Dr. O. F. Guenther* for having served that community for 33 years. His colleague, *Dr. Leo Hoffmann*, introduced the recognition program. Following his tribute Doctor Guenther thanked the club for the honor bestowed upon him and explained how difficult it is to retire especially when all of your patients had become personal friends instead of customers.

Burlington Hospital Names Officers

When the Burlington Memorial Hospital medical staff met recently, *Dr. William Sroka* was elected president. Other officers elected were: *Drs. H. William Bardenwerper*, vice-president, and *Louis Kohn*, secretary.

New Clinic Planned for Colby

Lots have been purchased for the site of a new clinic which will be constructed soon in Colby. The clinic will be under the partnership of *Drs. J. W. Koch* and *R. L. Hansen.*

Dr. Cunningham Observes 86th Birthday

On September 19 *Dr. Wilson Cunningham* observed his 86th birthday by continuing his daily office schedule and serving the people of the Platteville area as he has done for the past 58 years. Still in the active practice of medicine, Doctor Cunningham assumes usual office hours and continues to receive night calls, but now leaves the surgery to younger men.

Doctor Cunningham

Dr. Baertsch Locates in Hayward

Dr. Lloyd M. Baertsch, a native of Fountain City, has been added to the staff of the Hayward Clinic. After serving three years in the U. S. Army, he entered medical school, graduating in 1956. Doctor Baertsch then interned at Wayne County General Hospital, Detroit, Michigan, and recently completed a one-year term of general practice residency at Hurley Hospital, Flint, Michigan.

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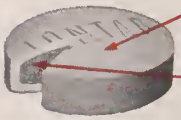

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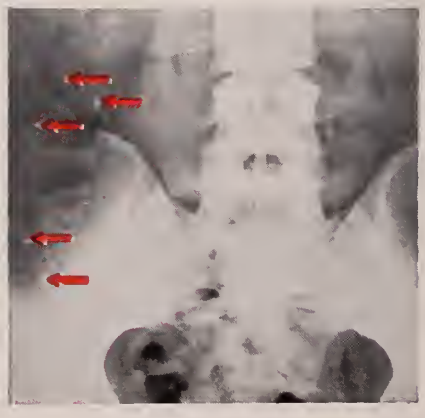
8 hours Lontabs are still visible as substance of core continues to be released.



THIRD AND TWELFTH DISTRICTS NEWS

Dr. Cheli Joins Columbus Clinic

It was recently announced that *Dr. Clement Cheli* purchased the interests of *Dr. H. M. Caldwell* in the Columbus Clinic. Doctor Cheli had practiced on an individual basis at Columbus for a number of years.

Madison Doctors Attend Meeting

During the week of October 24, *Dr. Charles W. Crumpton, Robin Allin* and *Arvin Weinstein,* all of Madison, attended the 34th annual meeting of the American Heart Association at San Francisco. They were among seven Wisconsin physicians serving as delegates of the State at the sessions.

Postgraduate Clinic Held in Madison

Included on the roster of speakers at the 28th annual Marquette–Jackson Clinic postgraduate program held October 3 in Madison were: *Drs. Arnold S. Jackson, James W. Messer,* Raymond O. Swann, *William B. Parson, Jr.,* and *John R. Steeper,* all of the Jackson Clinic, Madison; and Drs. Eugene S. Turrell, Earl G. Schulz, and *Julius M. Meyer,* of the Marquette University School of Medicine. Following the scientific meeting the physicians attended the Wisconsin–Marquette football game.

New Doctor in Verona

A 1956 graduate of the University of Wisconsin School of Medicine, *Dr. Curtis C. Knight,* opened his first office at Verona in early August. Before locating in that city, Doctor Knight interned and served a year of surgery residency at Madison General Hospital.

Milwaukee Doctor Elected to Office

The American Academy of Physical Medicine and Rehabilitation has announced the election of *Dr. Ray Piaskoski* as Vice-President of the organization for the 1958–59 term. Doctor Piaskoski holds the position of chief of the physical medicine and rehabilitation service at the Veterans Administration Hospital in Wood.

Milwaukee Academy of Medicine

"Electrolyte Problems and Renal Disease" will be the main topic of discussion at a series of conferences, clinics, and ward rounds for the medical public to be held from Tuesday evening through Saturday, December 16–20, at Milwaukee. The sessions are being presented by the Milwaukee Academy of Medicine and are open to interested physicians without registration fee.

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(1) Hagedorn, A. B.: Proc. Staff Meet. Mayo Clin. 32:705 (Dec. 11) 1957.
(2) Best, W. R.; Louis, J., and Limarzi, L. R.: M. Clin. North America (Jan.) 1958, p. 3.

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Jackson Clinic and Foundation Fall Postgraduate Meeting

The Jackson Clinic and Foundation fall postgraduate meeting was held Thursday, November 20, at Madison. "Problems in General Practice" was the theme. The morning session was headed by *Dr. Albert W. Bryan;* the afternoon session, by *Dr. Luther E. Holmgren. Dr. Margaret J. Prouty,* who went to Chile this summer on a mountain climbing trip, was the main banquet speaker in the evening. She talked on the "Highlights in Mountaineering."

New Faculty Members at UW

Three new appointments to the faculty of the University of Wisconsin Medical School were approved recently by the Board of Regents.

Dr. Francis Michael Forster, formerly dean of the Georgetown University School of Medicine, was named chairman of the department of neurology. *Dr. John H. Flinn,* who has been with the Jackson Clinic in Madison, was named associate professor and director of the Student Health Service. Dr. Gernot B. Rath, of Bonn University, Germany, was appointed visiting professor of history of medicine for the second semester of 1958–59.

Dr. Hardgrove Reelected to Post

Dr. Maurice Hardgrove has been reappointed Department Medical Advisor of the American Legion for 1958–59. Doctor Hardgrove, a Milwaukee internist, has been active in Veterans and Legion affairs for a number of years.

Two U of W Doctors Present Lectures

Dr. Charles W. Crumpton of the Medicine and Cardiovascular Research Laboratory at the University of Wisconsin participated in the third annual Robert Lyman Nelson Memorial Lecture on September 4, at Duluth, Minnesota. His talk was entitled, "Causative Factors in the Development of Atherosclerosis."

A physician from the same department of the University, *Dr. George G. Rowe,* attended the meeting of the American Society of Pharmacology and Experimental Therapeutics and presented a lecture on "The Coronary and Systemic Hemodynamic Effects of Salicylates." The meeting was held recently at Ann Arbor, Michigan.

Madison Surgeon Talks

"Surgery on Small Bowel Tumors" was the subject chosen by *Dr. Kenneth E. Lemmer* for his talk presented at the Board of Governors Meeting of the American College of Surgeons held in Chicago. Doctor Lemmer holds a position in the department of surgery at the University of Wisconsin Medical School.

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BECKER, M. C., Simon, F. and Bernstein, A.: J. Newark Beth Israel Hosp. **9**:58 (January) 1958.

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New Medical Library Fund Drive

Medical library facilities which 10 years ago were past the "critical stage of physical inadequacy" will be replaced by a proposed $850,000 building with completion of a University of Wisconsin Medical School alumni drive which is under way now.

The drive, first major project of the two-year-old Wisconsin Medical Alumni Association, is for the William S. Middleton Library Fund. *Doctor William S. Middleton* is the former dean of the UW Medical School who left in 1955 to become chief medical director for the Veterans Administration.

With 66,000 volumes on hand, and 2,200 more arriving each year, the need for more area is urgent.

In addition to serving medical students plus those in such fields as nursing, medical technology, and physical therapy, the present library is a reference center for students and faculty from other departments within the University.

In keeping with the UW idea of service to the entire state and community, the library also provides Wisconsin physicians with answers to their medical questions, or with packets of books and journals on topics such as new treatments or rare diseases.

This Medical Library Service, worked out by the School with the State Medical Society and the UW Extension Division, is also available to laymen, and many requests come in from other libraries.

Expansion of the library was one of Doctor Middleton's goals, and before he left the UW he had obtained pledges of some $65,000 toward his dream. To honor this and other contributions made by Doctor Middleton to development of the Medical School, the alumni decided to name the fund in his honor.

Plans for the building are still tentative, but preliminary sketches show a modern two-story structure. The proposed location is at the corner of Linden Drive and N. Randall Ave., across from the Orthopedic Hospital.

To spark the drive, the Medical Alumni Association has appointed regional chairmen in areas around the nation where members are concentrated. Most states have at least one such chairman; several have two. Wisconsin has more than a dozen.

Overall chairman of the drive is *Dr. Mischa Lustok*, Milwaukee. *Dr. Einar Daniels*, also of Milwaukee, is president of the association. Madison-area chairmen are *Drs. Eugene Nordby* and *A. R. Curreri.*

Contributions from friends of Doctor Middleton, former Medical Center patients, and any others who may wish to donate will be welcomed, but the Association hopes to raise most of the money from within its own ranks.

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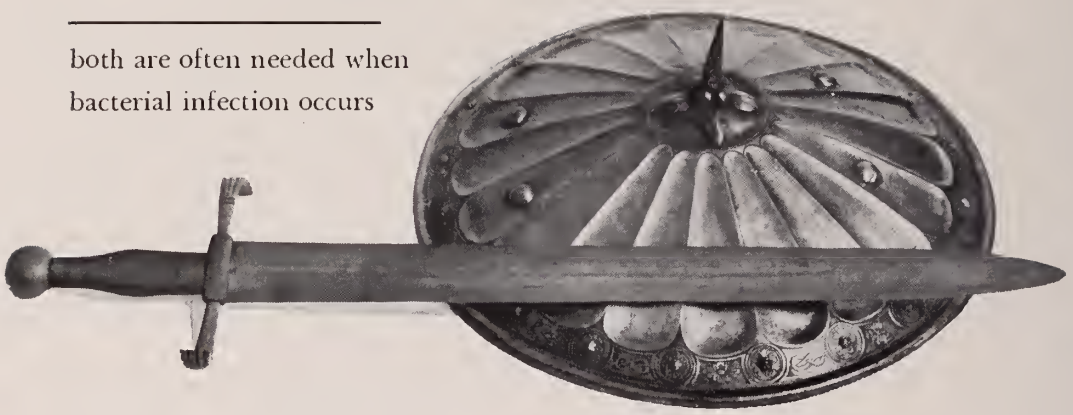

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UW Receives $40,000 Grant

A grant of $40,000 from The Oscar Rennebohm Foundation of Madison to the University of Wisconsin Medical School through the University of Wisconsin Foundation for support of lung capillary research was accepted recently by the UW Board of Regents.

The grant will be distributed over a five-year period. It will enable Dr. John Rankin, assistant professor of medicine and director of the Pulmonary Function Laboratory to expand research begun three years ago which perfected new methods of studying the millions of capillaries or tiny blood vessels in the lungs.

Dr. John Z. Bowers, dean of the UW Medical School, expressed the School's appreciation for the grant. "Private contributions for medical research, such as this Rennebohm grant, enable us to undertake projects that would otherwise be impossible," Dean Bowers explained. "The grant will also permit some fine young men to get superior quality training in internal medicine."

The study is designed to determine how the body adjusts the flow of blood through the capillaries to supply its oxygen needs. Doctors know that the flow increases when we exercise, but they don't know how this increase is triggered.

In addition to finding the factors involved in capillary control under healthy conditions, the program will be aimed at discovering controls which are important in chronic heart disease.

Some heart patients who aren't helped by surgery are found to have suffered damage to these capillaries. The heart disease may be cured but the damage can not be repaired. Doctor Rankin hopes to find out how the damage occurs.

Doctor Tolan Retires

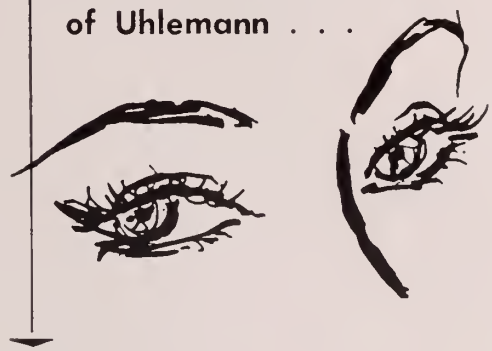
In October a dinner was given by the Milwaukee Oto-Ophthalmic Society in honor of *Dr. Thomas L. Tolan* who has retired. During his 37 years of practice in Milwaukee he was one of the founders of a program to detect hearing defects among Wisconsin children, served as former chairman of the state committee on conservation of hearing, and helped found the hearing aid bureau at the University of Wisconsin—Milwaukee and the Milwaukee otological clinic at Marquette University.

Doctor Tolan plans to spend the winter at Cuernavanca, Mexico, and next summer in Door County. He then intends to return to Milwaukee in the fall.

Boston Physician Speaks

Dr. Francis Cabot Lowell, Department of Medicine, Boston University School of Medicine, was guest lecturer at the 934th scientific meeting of the Milwaukee Academy of Medicine on Tuesday, October 21. Doctor Lowell's subject was "Obstructive Pulmonary Disease." The meeting was held at the University Club of Milwaukee.

When People Think of Uhlemann . . .



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PUBLISHED REFERENCES: 1. Carpenter, E. B.: Southern Medical Journal 51:627, 1958. 2. Forsyth, H. F.: J.A.M.A. 167:163, 1958. 3. Little, J. M., and Truitt, E. B., Jr.: J. Pharm. & Exper. Therap. 119:161, 1957. 4. Morgan, A. M., Truitt, E. B., Jr., and Little, J. M.: J. Am. Pharm. Assn., Sci. Ed. 46:374, 1957. 5. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:160, 1958. 6. Park, H. W.: J.A.M.A. 167:168, 1958. 7. Truitt, E. B., Jr., and Patterson, R. B., Proc. Soc. Exper. Bio. & Med. 95:422, 1957. 8. Truitt, E. B., Jr., Patterson, R. B., Morgan, A. M., and Little, J. M.: J. Pharm. & Exper. Therap. 119:189, 1957.

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CONDITION	NO. PATIENTS	RESPONSE			
STUDY 1[1]		"marked"	moderate	slight	none
Skeletal muscle spasm secondary to acute trauma	33	26	6	1	—
STUDY 2[2]		"pronounced"			
Herniated disc	39	25	13	—	1
Ligamentous strains	8	4	4	—	—
Torticollis	3	3	—	—	—
Whiplash injury	3	2	1	—	—
Contusions, fractures, and muscle soreness due to accidents	5	3	2	—	—
STUDY 3[5]		"excellent"			
Herniated disc	8	6	2	—	—
Acute fibromyositis	8	8	—	—	—
Torticollis	1	—	—	1	—
STUDY 4[6]		"significant"			
Pyramidal tract and acute myalgic disorders	30	27	—	2	1
TOTALS	138	104 (75.3%)	28 (20.3%)	4	2

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"In the author's clinical experience, methocarbamol has afforded greater relief of muscle spasm and pain for a longer period of time without undesirable side effects or toxic reactions than any other commonly used relaxants . . ."[2]

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"An excellent result, following methocarbamol administration, was obtained in all patients with acute skeletal muscle spasm."[5]

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Southern Medical Journal

"This study has demonstrated that methocarbamol (Robaxin) is a superior skeletal muscle relaxant in acute orthopedic conditions."[1]

OBITUARIES

Dr. H. M. Trankle, 78, died September 21. He had been retired from practice since 1955.

Born in 1880 at Bloomer, Doctor Trankle graduated from the Rusk Medical College at Chicago in 1901. He was located at Wabasha, Minnesota, and Andover, South Dakota, for a short time before settling in Bloomer. In 1942 he moved to the Northern Colony in Chippewa Falls.

During the time he was in Bloomer, Doctor Trankle was a member of the Chippewa County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include his widow, two sons, and two grandchildren.

Dr. John M. Conway, a retired Spring Valley physician, died September 22 at his summer home in Lake Tainter. He was 68 years of age.

He was born in 1889 at Elroy. Doctor Conway received his medical degree from the University of Illinois in 1915 and immediately began practice in Spring Valley where he remained until retiring in 1956. During his active years, Doctor Conway served on the Spring Valley school board and was also a health officer.

Doctor Conway is survived by his widow; a son, Dr. John E. Conway of Menasha; and a daughter, Mrs. R. W. DesJarlais, of Washington D.C.

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Society Records

NEW MEMBERS

R. F. Hudson, 405 South Farwell Street, Eau Claire.
J. B. Dibble, 405 South Farwell Street, Eau Claire.
C. I. Bowerman, St. Joseph's Hospital, Marshfield.
F. A. Neisius, 136½ Third Street, Baraboo.
J. T. Siebert, 101 Fourth Street, Baraboo.
M. F. Stuessy, Markesan.
J. K. Scott, 110 East Main Street, Madison.
W. C. Rouman, 204 West Wisconsin Avenue, Tomahawk.
C. R. Weatherhogg, 1023 Regent Street, Madison.
J. P. Rahm, Jr., 5001 Monona Drive, Madison.
R. A. Lende, 1300 University Avenue, Madison.

CHANGES OF ADDRESS

J. E. Schlichting, Wood, to 612 Huron Avenue, Sheboygan.
C. M. Shon, Milwaukee, ** to Third Marine Division Reinforced, FMF Pacific F80 San Francisco, California.
T. F. Meves, Wood, to 161 West Wisconsin Avenue, Milwaukee.
R. E. Fitzgerald, Milwaukee, to 1111 Milwaukee Avenue, Janesville.
J. W. Rupel, Milwaukee, to 512 Cypress Street, Marshfield.
R. C. Feulner, Milwaukee, to 1551 South 170th Street, Waukesha.
D. A. Smith, Milwaukee, to 111 Jackman Street, Janesville.
E. A. Cornelius, Beloit, to Hermann Hospital, Houston 25, Texas.
S. T. Gettelman, Racine, to MacCornack Clinic, Whitehall.
H. M. Stang, La Crosse, to Hayward.
E. D. Ravn, Jr., Madison, to 1802 Ninth Street, Merrill.
A. P. Crosley, Jr., Madison, to 767 Worthington Drive, Warminster, Pennsylvania.
J. M. Grinde, Weyburn, Saskatchewan, Canada, to De Forest.

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1. Welsh, A. L., and Ede, M.: J.A.M.A. *166*:158, 1958.
2. Bleiberg, J.: J.M. Soc. New Jersey *53*:37, 1956.
3. Abrams, B. P., and Shaw, C.: Clin. Med. *3*:839, 1956.
4. Bleiberg, J.: Am. Practitioner *8*:1404, 1957.
5. Clyman, S. G.: Postgrad. Med. *21*:309, 1957.

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RECENT WISCONSIN LICENTIATES

The following physicians were granted licenses by reciprocity by the State Board of Medical Examiners at a meeting in Milwaukee, July 8–10, 1958:

Name	*School of Graduation*	*Year*	*City*
Ahlbrand, R. C.	Indiana University	1955	Wisconsin Rapids
Atkinson, W. T., Jr.	St. Louis University	1955	Brentwood, Missouri
Balder, R. B., Jr.	University of Colorado	1957	Hillsboro
Berkley, K. M.	University of Rochester	1946	Janesville
Bouras, George	University of Vermont	1955	Milwaukee
Burris, B. C.	University of Tennessee	1946	Milwaukee
Carter, R. G.	University of Washington	1957	Washburn
Champlin, F. B.	Cornell University	1943	Milwaukee
Craven, R. E.	Creighton University	1957	Milwaukee
Edwards, Howard, Jr.	Cornell University	1945	Dixon, Illinois
Ellison, E. H.	Ohio State University	1943	Milwaukee
Farrington, J. D.	Rush Medical College	1935	Minocqua
Finlayson, W. E.	Meharry Medical College	1953	Milwaukee
Foderick, J. W.	University of Western Ontario	1950	Mogadore, Ohio
Guildner, C. W.	University of Nebraska	1957	Madison
Haines, A. W.	University of Michigan	1957	Green Bay
Halleck, S. L.	University of Chicago	1952	Madison
Harris, B. A.	Ohio State University	1957	Milwaukee
Hayden, J. W.	Syracuse University	1947	La Crosse
Hickman, M. J.	University of Michigan	1954	Madison
Johnson, D. E.	Oklahoma University	1954	Wood
Johnson, R. L.	Northwestern University	1956	Friendship
Johnston, R. E.	Ohio State University	1954	Newcastle, Indiana
Kalina, B. F.	University of Iowa	1954	Green Bay
Keskey, C. W.	University of Michigan	1954	Milwaukee
Lam, R. C.	Western China Union University	1945	Steilacoom, Washington
Latorraca, C. W.	Tufts College of Medicine	1949	Milwaukee
Luckey, W. T.	Indiana University	1957	Milwaukee
McGuire, J. M.	Long Island College	1949	Milwaukee
O'Brien, M. J.	University of Illinois	1955	Mount Prospect, Illinois

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Name	School of Graduation	Year	City
Parks, W. C.	Meharry Medical College	1945	Milwaukee
Rahm, J. P., Jr.	University of Michigan	1953	Madison
Reiquam, C. W.	Northwestern University	1951	Madison
Salibi, B. S.	Harvard Medical School	1950	Marshfield
Saxl, George	University of Illinois	1950	Elmwood Park, Illinois
Schultz, J. H.	Hahnemann Medical College	1954	Jackson
Sheldon, E. O., Jr.	University of Michigan	1957	Madison
Sortor, R. F.	McGill University	1953	Garden City, Michigan
Stanley, R. A.	University of Illinois	1955	Ashland
Strawn, E. Y.	Meharry Medical School	1952	Milwaukee
Stone, W. N.	Vanderbilt University	1957	Madison
Strong, Jack	University of Illinois	1953	Mauston
Szemer, E. A.	Northwestern University	1954	Wauwatosa
Tompkins, D. G.	College of Physicians and Surgeons	1950	La Crosse
Turrell, E. S.	Indiana University	1947	Wauwatosa
Wall, Thomas	Western Reserve University	1952	Milwaukee
Weingarten, Maxwell	University of Toronto	1945	Milwaukee
Wilcox, W. A.	Northwestern University	1950	Milwaukee
Young, H. C.	Tufts College of Medicine	1949	Greenfield

The following physicians were granted licenses by examination by the State Board of Medical Examiners at a meeting in Milwaukee, July 8–10, 1958:

Name	School of Graduation	Year	City
Abboud, F. M.	University of Cairo	1955	Milwaukee
Ahiassaf, G. C.	University of Geneva	1955	Milwaukee
Aktekin, Hikmet	Istanru University	1951	Country of Turkey
Aufderhaar, H. W.	University of Wisconsin	1957	Fort Atkinson
Bartos, R. E.	Marquette University	1957	Milwaukee
Beach, T. B.	University of Wisconsin	1957	Oakland, California
Berg, J. F.	Marquette University	1957	Milwaukee
Biever, P. H.	Marquette University	1957	Port Washington
Bradley, D. D.	University of Wisconsin	1957	Milwaukee
Brandenburg, J. H.	University of Wisconsin	1956	Madison
Bremner, J. E.	University of Ottawa	1955	Milwaukee
Bures, J. U.	Marquette University	1957	Greenville, South Carolina
Capelli, P. A.	Marquette University	1956	Kenosha
Carlson, S. D.	Marquette University	1957	Arcadia
Chelius, C. J.	University of Kiel	1954	Cudahy
Clinton, G. L.	University of Wisconsin	1957	Madison
Cooperman, L. R.	Jefferson Medical College	1957	Madison
Denig, C. M.	Marquette University	1957	Lake Geneva
Doberneck, R. C.	Marquette University	1956	Minneapolis, Minnesota
Dunn, W. J.	Marquette University	1957	Chicago, Illinois
Dunnigan, W. J.	Hahnemann Medical College	1957	Madison
Edson, J. D.	University of Wisconsin	1957	Madison
Ellis, J. C., Jr.	University of Wisconsin	1957	Madison
Faillace, L. A.	Marquette University	1957	New York, New York
Ferwerda, J. R.	University of Wisconsin	1957	Clinton
Flynn, J. F.	Marquette University	1957	Albany, New York
Fox, T. C.	University of Wisconsin	1957	Racine
Fritz, R. J.	Marquette University	1957	Milwaukee
Gallo, G. L.	University of Wisconsin	1957	Oconomowoc
Gander, E. P.	Marquette University	1957	Allenton
Gerger, H. K.	Humboldt University	1952	Milwaukee
Gruesen, R. A.	Marquette University	1957	Madison
Gustavson, W. H.	University of Illinois	1957	San Antonio, Texas
Hare, J. D.	Queen's University	1950	Madison
Haswell, J. N.	University of Wisconsin	1957	Madison
Hayes, J. R.	University of Washington	1957	Milwaukee
Helliesen, P. J.	University of Zurich	1951	La Crosse
Hill, R. D.	McGill University	1954	Detroit, Michigan
Hoffman, P. A., Jr.	University of Wisconsin	1957	Shawano
Holt, G. E.	University of Wisconsin	1957	Madison
James, J. R.	University of Wisconsin	1957	Winter Park, Florida
Jewkes, R. F.	University of London	1956	Madison
Karrmann, P. L., Jr.	Marquette University	1957	Milwaukee
Karsten, F. A.	Marquette University	1957	Horicon
Kaufmann, W. C.	University of Berne	1956	Milwaukee
Kinkel, D. M.	University of Wisconsin	1957	Waupun
Klamecki, B. J.	Marquette University	1957	Milwaukee
Klingbeil, G. G.	University of Illinois	1957	Milwaukee

Name	*School of Graduation*	*Year*	*City*
Klingbeil, R. E.	University of Illinois	1957	Milwaukee
Kottke, M. A.	Marquette University	1957	Milwaukee
Kozina, T. J.	Marquette University	1957	Milwaukee
Kroening, P. M.	University of Wisconsin	1957	Wausau
Kwan, F. P.	Marquette University	1957	Milwaukee
Leschke, J. A.	Marquette University	1957	Oshkosh
Leverenz, R. L.	Marquette University	1957	Milwaukee
Liebman, M. H.	University of Wisconsin	1957	Palo Alto, California
Liechty, J. D.	Northwestern University	1957	Lake Geneva
Lindsay, E. R.	Columbia University	1954	Madison
Lipscomb, C. R.	Marquette University	1957	Wauwatosa
Mallin, S. R.	University of Wisconsin	1957	Milwaukee
Marta, J. B.	Marquette University	1957	Laurium, Michigan
Martens, T. J.	University of Wisconsin	1957	Goodman
McCabe, R. W.	Marquette University	1957	Wood
McRae, J. A.	Marquette University	1957	Milwaukee
Meyers, Alfred	Marquette University	1957	Columbus, Ohio
Miller, D. D.	University of Chicago	1956	Monroe
Moriarty, J. D.	Marquette University	1957	Brookings, South Dakota
Murphy, F. D., Jr.	Marquette University	1957	Milwaukee
Murray, R. C.	Marquette University	1957	Milwaukee
Ney, J. E.	Marquette University	1955	Milwaukee
Nicolaus, W. H.	University of Wisconsin	1957	Milwaukee
Noonan, P. J.	Marquette University	1957	Wood
Novak, R. F.	Loyola University	1957	Madison
Nuland, S. J.	University of Wisconsin	1955	Madison
O'Dell, L. W.	University of Oregon	1957	Milwaukee
Olson, R. W.	University of Wisconsin	1957	Madison
Orman, E. S.	University of Wisconsin	1957	Cudahy
Oxman, H. L.	University of Wisconsin	1957	Milwaukee
Payne, J. C.	University of Wisconsin	1957	Oshkosh
Peterson, F. N.	Northwestern University	1940	Oconomowoc
Pfefferkorn, E. D.	University of Wisconsin	1957	Oshkosh
Pointer, R. W.	University of Wisconsin	1957	Madison
Powell, G. F.	Marquette University	1957	Baltimore, Maryland
Quinn, G. A.	Marquette University	1957	Milwaukee
Raasch, H. M.	Marquette University	1957	Milwaukee
Rankin, John	University of Wisconsin	1947	Madison
Rasmussen, R. J.	University of Wisconsin	1957	Waukesha
Redfield, J. T.	University of Wisconsin	1957	Madison
Rosenberg, L. E.	University of Wisconsin	1957	Coytesville, New Jersey
Ryan, E. A.	Marquette University	1957	Duluth, Minnesota
Saltzstein, E. C.	Northwestern University	1957	Chicago, Illinois
Sanders, E. A.	Marquette University	1957	Racine
Schmitt, A. C.	Marquette University	1957	Milwaukee
Schmitt, J. O.	Marquette University	1957	Milwaukee
Schoenwetter, C. D.	University of Wisconsin	1957	Madison
Schofield, Raymond	University of Wisconsin	1957	Oroville, California
Schulz, D. W.	University of Wisconsin	1956	Fort Knox, Kentucky
Simonsen, H. W.	University of Wisconsin	1957	Milwaukee
Skemp, C. A.	Marquette University	1957	La Crosse
Somerndike, J. M., Jr.	Temple University	1957	Milwaukee
Stadler, F. J., Jr.	Marquette University	1957	Milwaukee
Stiehm, E. R.	University of Wisconsin	1957	Madison
Szymanski, J. F.	University of Wisconsin	1957	Hales Corners
Taake, E. R.	University of Wisconsin	1957	Beaver Dam
Valdivia, Enrique	University of Chile	1949	Madison
Van Dyck, W. A., Jr.	Marquette University	1957	Wauwatosa
Van Hecke, D. C.	Marquette University	1956	Iowa City, Iowa
Vitulli, V. N.	Marquette University	1957	Milwaukee
Wagner, S. L.	University of Wisconsin	1957	Chicago, Illinois
Waldren, H. M., Jr.	Marquette University	1957	Milwaukee
Weigent, C. E.	University of Wisconsin	1957	Madison
Werra, R. J.	Marquette University	1957	Waukesha
Wiviott, Wilbert	University of Wisconsin	1957	Milwaukee
Woods, S. M.	University of Wisconsin	1957	Madison

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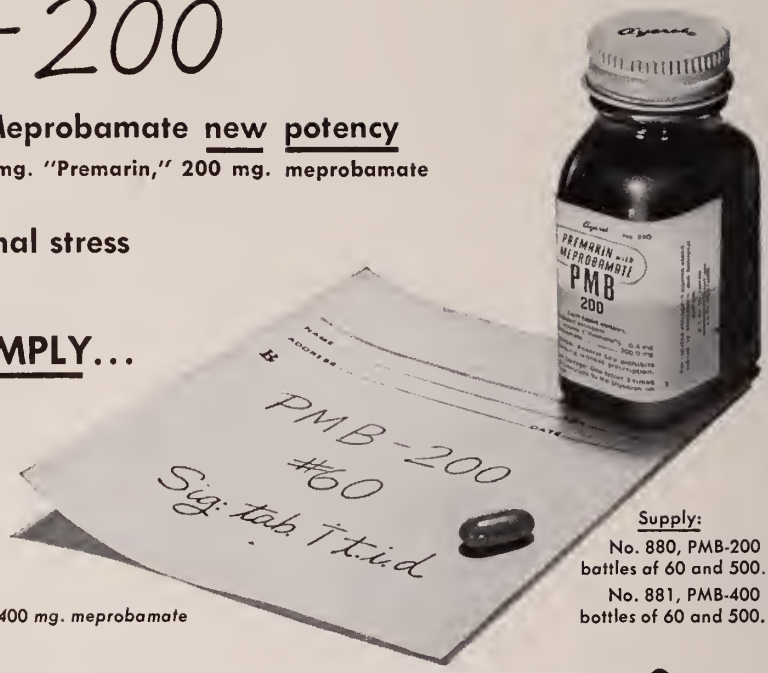

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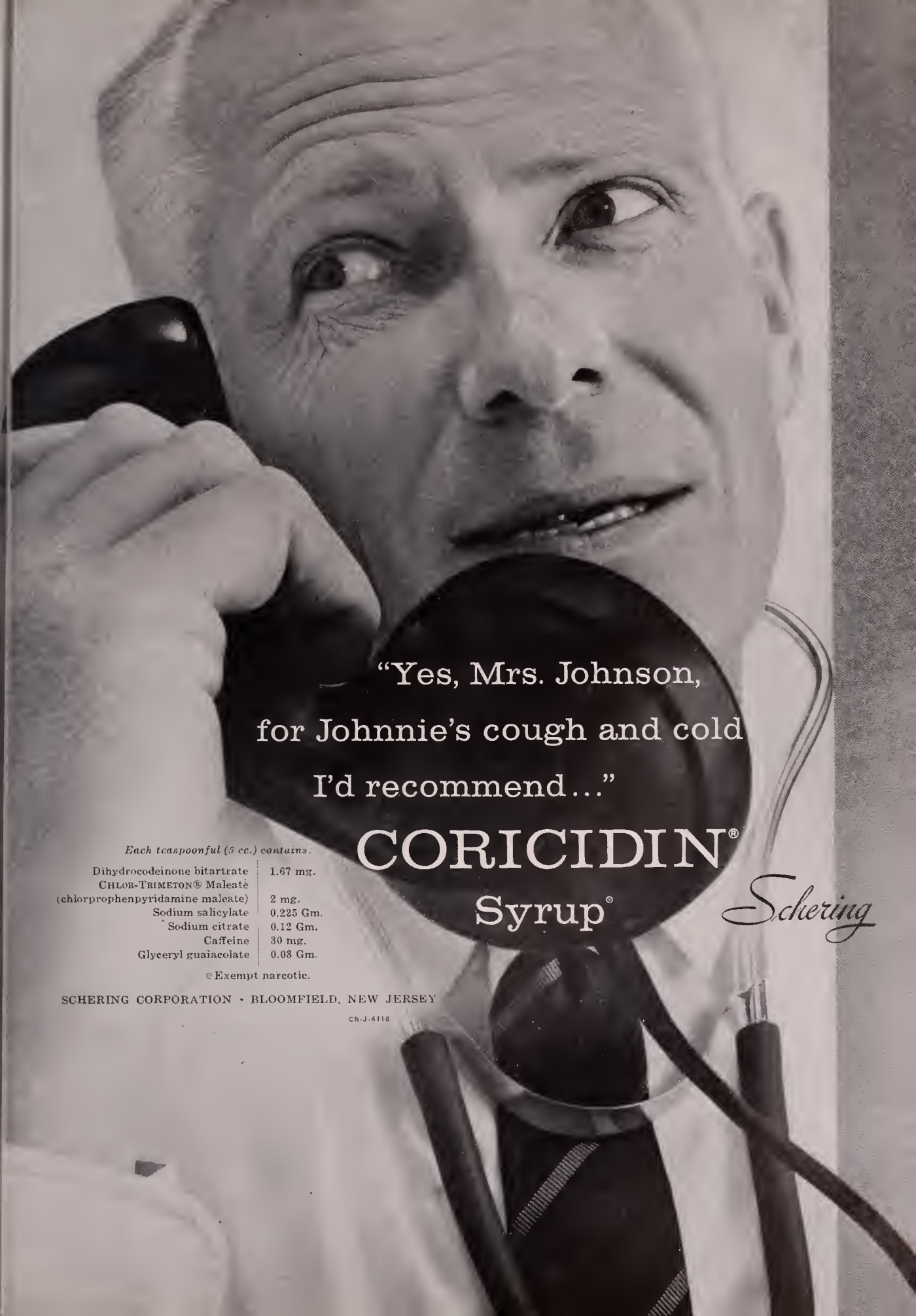
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2. Baird, H. W., III: A comparison of Meprospan (sustained action meprobamate capsule) with other tranquilizing and relaxing agents in children. Submitted for publication, 1958.

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BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interests of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison 6, Wisconsin.

A Bibliography of Internal Medicine: Communicable Diseases. By Arthur L. Bloomfield, M.D., Professor Emeritus of Medicine, Stanford University School of Medicine. The University of Chicago Press, Chicago. 1958. 560 pages. Price $10.00.

This volume is a small, but important, part of a selected bibliography of internal medicine compiled by Doctor Bloomfield in the study of the evolution of modern medicine. It has as its primary purpose the review of the contributions of medical investigators and observers of the past to the present day concepts of disease. This bibliography lists the important contributions of medicine of the nineteenth and twentieth centuries with critical comments which might be useful and stimulating to students and doctors to further reading and interest in events which led up to modern knowledge of communicable diseases. Essentially the text is a compilation of articles dealing with medical progress during the last century or so with the purpose of bridging the gap between current knowledge and the advances which preceded and have led up to it.

Most of the presently important communicable diseases are included in this compilation. Articles of both historical and scientific importance are referred to in their chronological order. These tend to place the new developments in modern concepts of disease in their proper perspective. Succinct and critical comments by the author about most of the references are not only informative but conducive to further library research.

I can not recommend this volume as a practical, quick reference on communicable diseases for the busy practitioner. For the student of medicine and the student of the history of medicine it is a must. For the educator who should be interested in the historical development of present day concepts of disease, study of the articles compended in this bibliography should encourage the course of humanism in this day of impersonal mechanomedicine. —*John H. Flinn, M.D.*

Rehabilitation After Illness and Accident. Edited by Thomas M. Ling, M.D., M.R.C.P., Consultant Psychiatrist to the Marlborough Day Hospital; and C. J. S. O'Malley, C.B.E., M.B., Medical Director, Camden Road Rehabilitation Center. Bailliere, Tindall and Cox, London (The Williams & Wilkins Co., Baltimore, exclusive U.S. agents). 1958. 119 pages. Price $3.50.

This rather interesting little British book deals with some aspects of rehabilitation which are often neglected, particularly in its first two chapters entitled "Emotional Factors in Rehabilitation" and "Return to Work." There is a good discussion of the adjustment of the patient from a more or less active outside life to life of a "rehabilitation case", and there is at least an attempt to come to grips with what is often the most unsatisfactory phase of rehabilitation, the patient's return from rehabilitation care to outside activity, preferably employment. This book is written for British conditions but many of the problems (the need for part time work, for some rehabilitation supervision in the early job phases, employment and even government red tape) are only too well known in this country.

Many of the other chapters in the book are more or less similar to what one finds in other books like this. Descriptions are given of what rehabilitation can do in medical, orthopedic, and neurological cases. These are too limited for experts, they would be a good introduction to the busy physician into the field of rehabilitation, and give him an idea of at least some of the things that are going on. The small size of the book (114 small pages) is an advantage. No attempt has been made to discuss the basic concepts of rehabilitation, its extent and limitations. If this had been done the book would have had to be at least three times its present size.

In summary this is a good small book for the busy physician who wants to have a general idea of what rehabilitation is all about, and who is willing to leave the details to the experts.—*H. D. Bouman, M.D.*

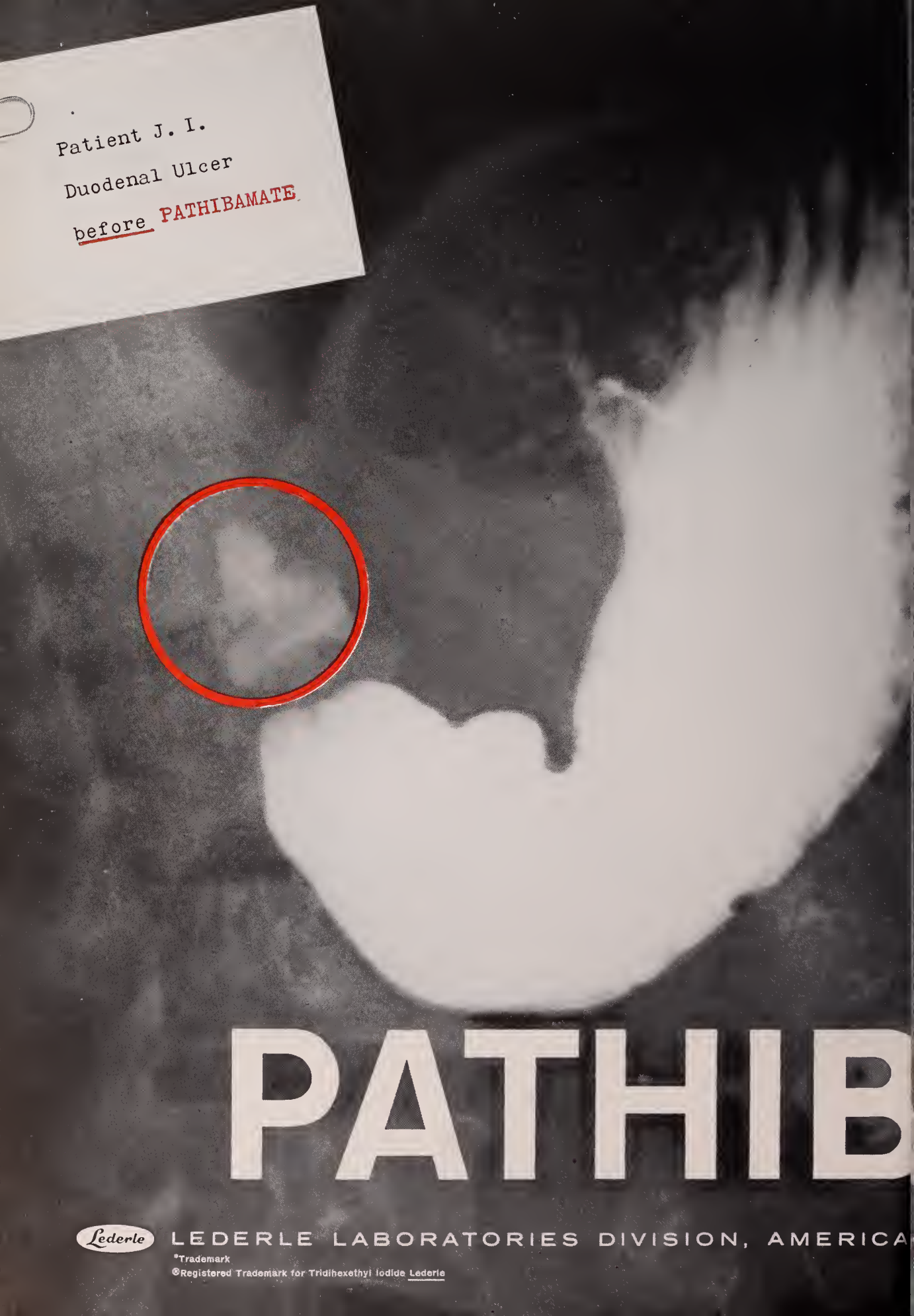
BOOKS RECEIVED

Negroes and Medicine. By Dietrich C. Reitzes, a teacher of sociology at Indiana University. A Commonwealth Fund Book. Harvard University Press, Cambridge 38, Mass. 1958. 400 pages. Price $7.00.

The Eternal Search. By Richard Mathison, a magazine writer and a newspaper reporter, now on the staff of the Los Angeles Times. G. P. Putnam's Sons, 210 Madison Ave., New York City. 1958. 381 pages. Price $5.95.

Clinical Obstetrics and Gynecology. Toxemias of Pregnancy, edited by Louis M. Hellman, M.D. Fibromyomas of the Uterus, edited by Robert A. Kimbrough, M.D. Volume 1, Number 2. Paul B. Hoeber, Inc., 49 East 33 St., New York 16, N.Y. 1958.

(Continued on page 72)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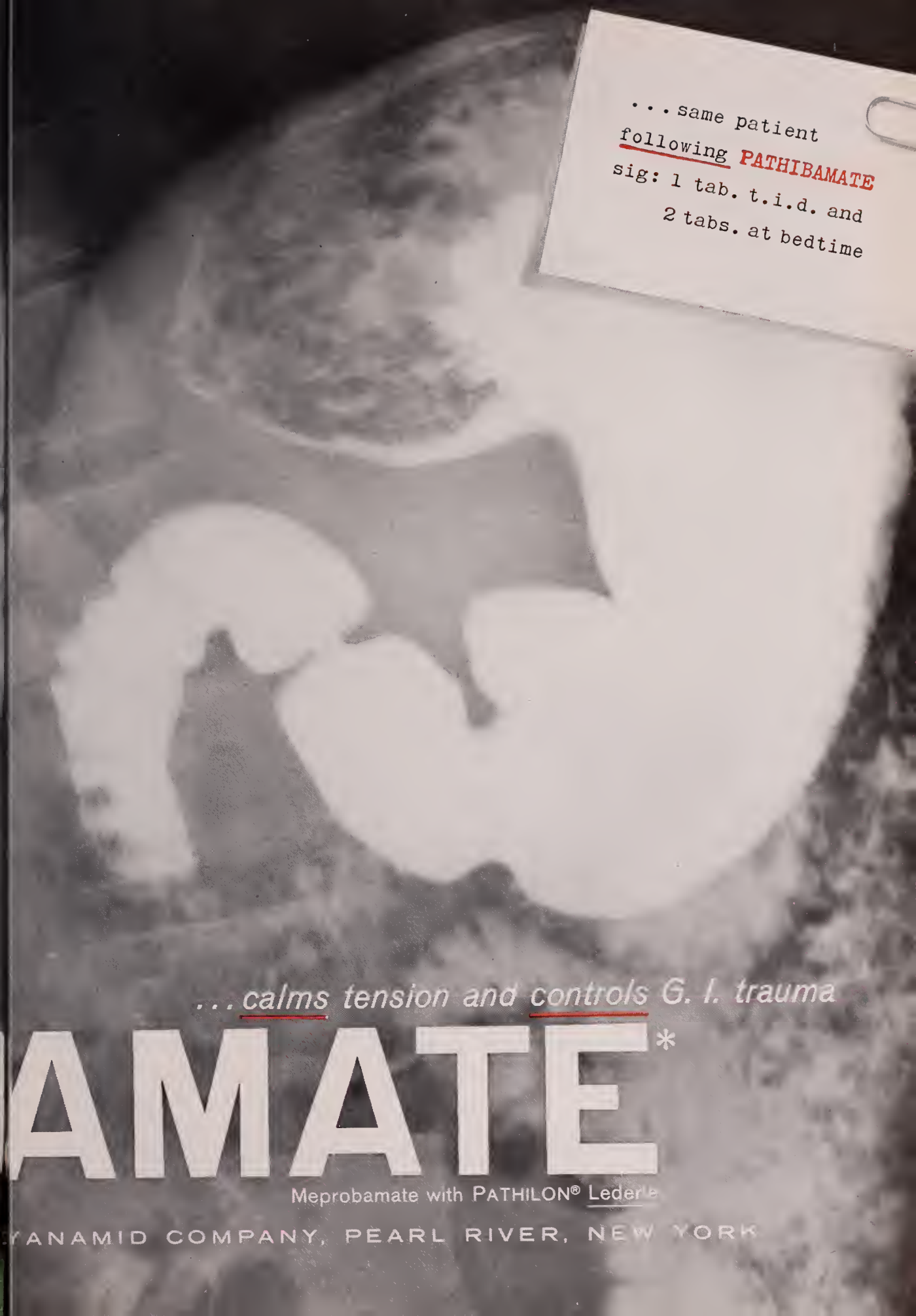
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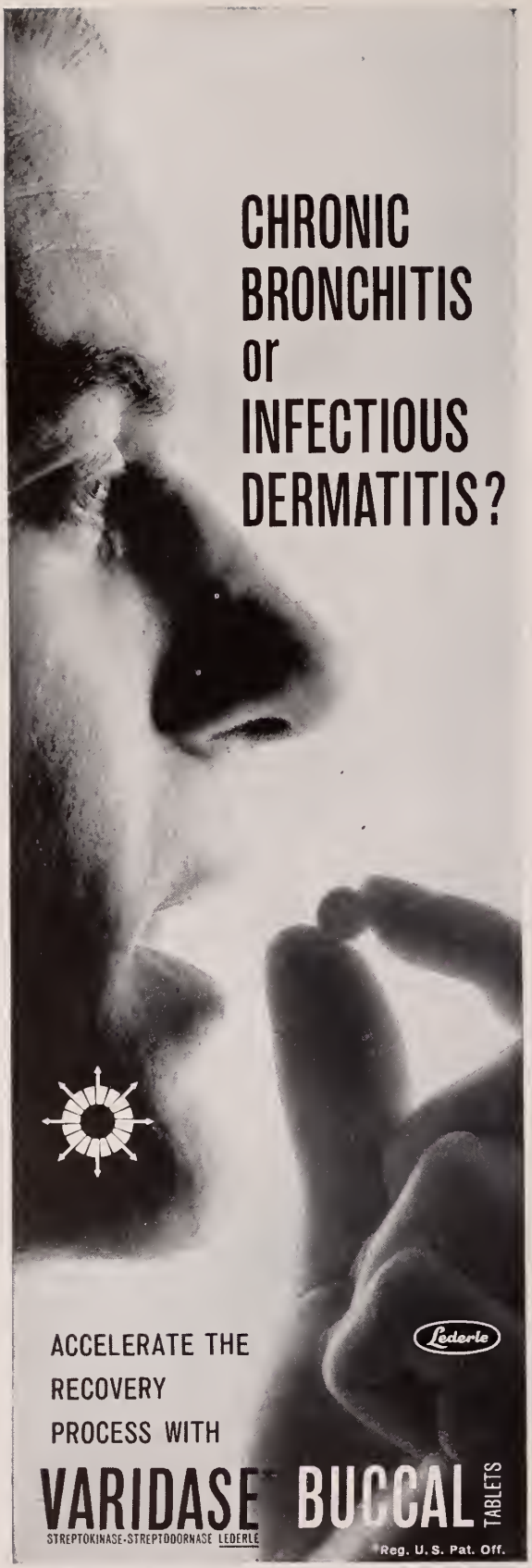

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(Continued from page 69)

How To Live with Diabetes. By Henry Dolger, M.D., and Bernard Seeman. Doctor Dolger is Chief of the Diabetes Clinic and Prenatal Diabetic Clinic, The Mount Sinai Hospital, New York; and Mr. Seeman is a professional writer who has specialized in articles on science and medicine. W. W. Norton & Company, Inc., 55 Fifth Avenue, New York 3, N.Y. 1958. 192 pages. Price $3.50.

Crime and Insanity. Edited by Richard W. Nice. Philosophical Library, Inc.. 15 East 40th Street, New York 3, N.Y. 1958. 280 pages. Price $6.00.

Medical Electrical Equipment. By Robert E. Molloy, M.B., F.F.A., R.C.S., advisory editor. Philosophical Library, Inc., New York. 1958. 312 pages. Price $15.00.

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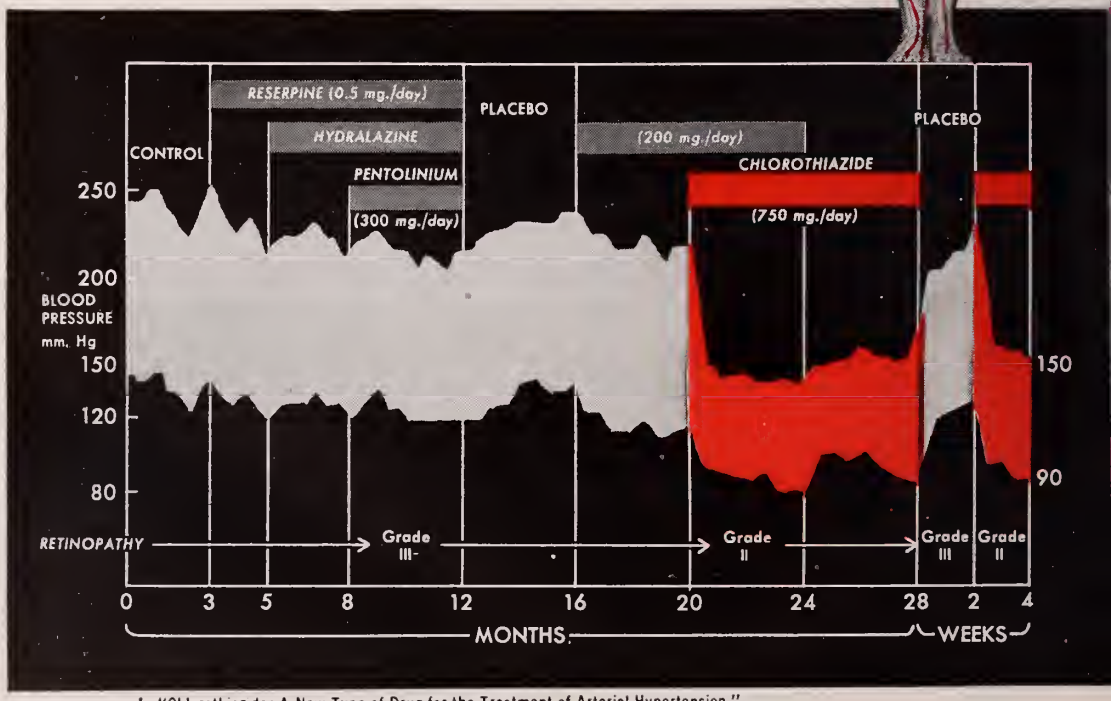
Wilkins, R. W.: New England J. Med. **257**:1026, Nov. 21, 1957.

"Chlorothiazide added to other antihypertensive drugs reduced the blood pressure in 19 of 23 hypertensive patients." "All of 11 hypertension subjects in whom splanchnicectomy had been performed had a striking blood pressure response to oral administration of chlorothiazide." ". . . it is not hypotensive in normotensive patients with congestive heart failure, in whom it is markedly diuretic; it is hypotensive in both compensated and decompensated hypertensive patients (in the former without congestive heart failure, it is not markedly diuretic, whereas in the latter in congestive heart failure, it is markedly diuretic). . . ."

Freis, E. D., Wanko, A., Wilson, I. H. and Parrish, A. E.: J.A.M.A. **166**:137, Jan. 11, 1958.

"Chlorothiazide (maintenance dose, 0.5 Gm. twice daily) added to the regimen of 73 ambulatory hypertensive patients who were receiving other antihypertensive drugs as well caused an additional reduction [16%] of blood pressure." "The advantages of chlorothiazide were (1) significant antihypertensive effect in a high percentage of patients, particularly when combined with other agents, (2) absence of significant side effects or toxicity in the dosages used, (3) absence of tolerance (at least thus far), and (4) effectiveness with simple 'rule of thumb' oral dosage schedules."



In "Chlorothiazide: A New Type of Drug for the Treatment of Arterial Hypertension," Hollander, W. and Wilkins, R. W.: Boston Med. Quart. **8**: 1, September, 1957.

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THE MEDICAL FORUM

HIGH COURT RULES AGAINST KENOSHA CHIROPRACTOR

S-S Resumes M.D. Examinations

MADISON—Local draft boards have resumed physical examination of physicians under 35 who are classified in Class 1-A, Col. Bentley Courtenay, state director of Selective Service, reported recently.

Examinations had been suspended since the doctor draft law expired July 1, 1957. Physicians under 35 who were classified in Class IV-F will be re-examined, the director said.

The resumption of examinations was directed by Selective Service National Headquarters following receipt of advice from the Department of Defense that too few physicians were volunteering for active duty or entry into armed forces residency training programs.

If this trend continues, Col. Courtenay said, the Selective Service system could be called upon to deliver physicians for induction. Therefore, local boards, in anticipation of such a special call, resumed examinations.

No information has been received in Wisconsin Selective Service headquarters concerning an induction call, although most physical examinations are expected to be ordered during November.

Interns now deferred in Class 11–A may be examined next spring, according to the director.

Union Directors Back Group Plans

WASHINGTON, D.C.—Group plans for purchasing medical care are necessary to protect the public from incompetent physicians, health directors of labor unions said at a meeting of the National Conference of Labor Health Services. They said that group third party guidance between doctor and patient is required to obtain adequate hospital and medical care of high quality.

Dr. A. H. Heidner

NAME WISCONSIN AMEF CHAIRMAN

Chicago—Dr. A. H. Heidner, West Bend, Wisconsin state chairman for the American Medical Education Foundation, will attend the eighth annual meeting of chairmen here Jan. 24–25.

Set Dates for 1959 Youth Conference

MADISON—Initial plans for the sixth Governor's Conference on Children and Youth, to be held April 3–4, 1959, were announced recently.

Dr. H. Kent Tenney, Madison, chairman of the Wisconsin Committee on Children and Youth, said the conference would play an important role in preparing Wisconsin's report to the White House Conference on Children and Youth, called by Pres. Eisenhower for March, 1960.

Gov. Thomson announced the appointment of Mrs. Karl Kleinpell, Cassville, as general chairman of the Wisconsin session, and Richard W. Whinfield, Madison, as program chairman.

Dr. C. A. Grand, Ashland, was named to head the Ashland County committee, created to stimulate active local participation in the state and national conferences.

Definition of Chiropractic Left To Board Rule

MADISON—While the State Supreme Court recently ruled against the current techniques employed by a Kenosha chiropractor, it also apparently ruled that Wisconsin law gives the Chiropractic Board of Examiners license to define chiropractic almost as it chooses.

The high court affirmed a decision by Circuit Judge Eugene M. Baker, Kenosha, who had held that the work of a chiropractor involved "adjustments of the articulations of the human spine by hand only."

The decision has the effect of banning Robert L. Grayson, Kenosha, and other chiropractors in Wisconsin from following practices such as taking blood samples and using instruments in their practice.

Justice George R. Currie, who wrote the supreme court decision, said Sec. 147.14 of the state statutes, relating to licensing of chiropractors, does not now contain a definition of the word *chiropractic.*

He said the Wisconsin Administrative Procedure Act conferred certain rule-making powers on the Chiropractic Board of Examiners, adding:

". . . . the legislature has lodged with a state administrative agency, the Chiropractic Board of Examiners, by Sec. 227.014 (1) (a), stats. It is difficult for us to conceive of any rule more necessary for such board to adopt, in effectuating the purpose of the chiropractic licensing statute, than one which defines the term 'chiropractic.' The validity of such definition embodied in the rule, which such board promulgated as Sec. Chir. 1.14 of the Wisconsin Administrative Code, is dependent upon whether it 'exceeds the bounds of correct interpretation.' "

While the law thus apparently leaves the door open for the board to change the definition of the term chiropractic, the present Wisconsin

(Continued on page 78)

CHIRO . . .

(Continued from page 77)

Code rules, as published by the board, reads as follows:

"Chir. 1.14 'Chiropractic Defined.'

"The science of chiropractic is based upon the premise that disease or abnormal function is caused by interference with normal nerve transmission and expression, due primarily to pressure, strain, irritation or tension upon the spinal nerves as they emit from the spinal column, as a result of bony segments, especially of the spine, deviating from their normal juxtaposition. The practice of chiropractic consists of the analysis of any interference with normal nerve transmissions and expressions and the correction thereof by a special adjustment with the hands of the abnormal deviations of the bony articulations, especially of the spine, for the removal of the cause of the disease, without the use of drugs or surgery. The term, analysis, is construed to include the use of x-ray and other analytical instruments generally used in the practice of chiropractic.

"Chir. 3.01. 'Supplemental Procedures.'

"(1) The use of diagnostic instruments as taught in the chiropractic colleges and generally used in chiropractic practice, as well as purely relaxing adjuncts such as heat lamps or hot towels, used preparatory to the adjustment, are permissible. The use of instruments or machines constituting special therapies in themselves, such as Colonic irrigators, diathermy, plasmatic, short wave, radionics, ultrasonic and others, are considered outside the scope of chiropractic practice in Wisconsin. *(The foregoing are illustrative only and are not meant to be all inclusive.)*

"(2) Supplementary foods may be supplied for nutritional purposes in the original container, but may not be dispensed nor prescribed for specific conditions.

"Chir. 3.02. 'X-Ray.'

"(1) X-Ray may be used for diagnostic or analytical purposes only."

Justice Currie said:

"It appears that most of the methods and instrumentalities employed by the defendant . . . are beyond the scope of the defendant's chiropractic license. Furthermore, if the validity of the rules is upheld, none of the attacked paragraphs of his answer would constitute a defense, and the trial court properly sustained the demurrer hereto."

Atty. Gen. Stewart G. Honeck, acting for the state, sought the high court ruling to block the use of instruments by chiropractors. The suit against Grayson alleged he took blood samples with a Spencer hemoglobinometer; gave psychosomatic counselling; used a DeWells detoxicolon devide to introduce water into the intestinal tract; used a plasmatic machine to raise body temperature with electricity; made use of a Raylax cable to vibrate the patients and a Myofasciatron low voltage generator to give patients electric shocks.

Grayson's attorneys protested that by limiting chiropractors to using their hands only, the court was "overlooking 33 years of scientific advances in the field," and that modern practice gave chiropractors much wider latitude.

Declare Disability Insurance Week

MILWAUKEE—Wisconsin held its first "Disability Insurance Week" this fall, on proclamation by Gov. Vernon Thomson.

The chief executive and Insurance Commissioner Paul J. Rogan were featured speakers at the annual meeting of the Wisconsin Association of Accident and Health Underwriters.

Gov. Thomson told the group that state regulation of health and accident insurance is in the best interests of the general public, declaring:

"If this regulation became the responsibility of some federal agency, Wisconsin residents would not get the consideration they now get from the state's own commission."

Commissioner Rogan said that accident and health agents should put the service element of their function to the forefront and make themselves available for consultation after the policy has been sold.

BUFFALO BLUE CROSS ASKS RATE HIKE

BUFFALO, N. Y.—The Buffalo Blue Cross applied in July for an average increase of 40.72 per cent in rates. Public hearings were scheduled on the petition.

MEMO: NEW FILMS

CHICAGO — Brand new, and available, these new films:

"You Are There: The Discovery of Anesthesia"—25 minutes; suitable for lay audiences; dramatizing the first time ether was used successfully in a surgical operation.

"You Are There: The First Major Test of Penicillin"—25 minutes; non-scientific; Demonstrates the place of scientific development in modern medicine and its influence on both peace and war, and also preparations for testing the drug on a group of wounded soldiers.

"Someone is Watching"—16 minutes; depicts actual cases from the files of the New York State Health Department's Bureau of Narcotics Control.

The films are 16mm, sound and black and white. They may be obtained by writing the A.M.A. Film Library, or the State Medical Society of Wisconsin, Box 1109, Madison 1.

ONE WAY OF HANDLING IT . . .

ALBUQUERQUE, N. M.—When the state welfare department announced it was reducing its fee schedule for physicians, members of the New Mexico Medical Society announced they would treat welfare patients for nothing, rather than take the cut.

The doctors were not trying to be difficult. They just hoped their stand might promote some badly-needed reforms in the handling of welfare applicants. The real problem, they felt, lay in a clause permitting physicians to treat only persons with life-endangering conditions. This meant that most of the funds were being eaten up by hospitals keeping chronically ill patients who could be treated more economically at home.

To sound members out, society officials first visited each county society, found doctors in unanimous agreement to refuse the cut.

The welfare department went back to the original fee schedule and agreed to liberalize benefits (and actually saving money) by allowing welfare recipients to stay in nursing homes and visit their physicians more frequently.

Map Plans for Legislative Bill Calling for Children's Center

MADISON—Final details concerning a proposal calling for a residential treatment center for emotionally disturbed children were ironed out this fall by the Legislative Council's Committee on Mental Health and Problems of Children and Youth.

A similar plan was turned down by the 1957 legislature.

The new proposal would provide care for 25–30 patients and could be built, its backers stated, for about $500,000, with operational expenses estimated at $350,000 a year. The bill is expected to come up early during the 1959 legislature.

On motion of State Sen. W. R. Moser (D–Milwaukee), the committee voted unanimously to ask that the State Department of Public Welfare be the authority in control of the center, and that it maintain close relationship with the University of Wisconsin Medical School for the conduct of educational and research programs within this facility. Plans call for the center to be built near the school in Madison.

PILOT STUDY

There is danger, Sen. Moser said, of losing sight of the fact that the center is to be a pilot study, and that the language of the law should be broad enough to make administration of the program in future years an activity free of jurisdictional disputes.

"Otherwise," he declared, "this pilot study will be one of the worst montrosities and spenders that we have ever seen."

Wilbur J. Schmidt, department director, said he was confident that details of cooperation would not have to be spelled out in the statutes, because his department would not appoint anyone to the professional staff without the approval of the medical school.

At an earlier hearing, Dr. Harold F. Borenz, of the Wisconsin Medical School, told the committee that the center would make possible the serving of the children, the training of psychiatrists, and the developing of opportunities for research.

He said that by treating children early it would be possible, in many cases, to prevent lifelong confinement of adults.

Blue Cross Gets 22.3% Rate Hike In New York City

NEW YORK—Blue Cross in New York City has been denied its "desperate plea" for an average 40 per cent increase in rates. The state superintendent of insurance approved instead a 22.3 per cent "emergency" boost pending completion of a Columbia University study of all nonprofit hospital, surgical and medical plans in the state.

OFFER NEW TYPE OF RADIO SERIES

CHICAGO—"Youth Speaks Up" is a new series of A. M. A. radio programs being made available to county medical societies this fall.

Fifteen minute programs prepared by the A. M. A. Bureau of Health Education, the three-part series offers pertinent comments by young people on boy–girl and parent–child relationships, school activities and world affairs. The participants include school leaders, slow and fast learners and problem cases.

Say M.D. Abuses In Charges Rare

LINCOLN, NEB.—The time has come to recognize that the instances of objectionable practice and abuse by physicians who overcharge because of insurance are relatively infinitesimal, E. J. Faulkner, president of the Woodman Accident-Life Insurance co., said recently.

Writing in the firm's magazine, Faulkner said such abuse as exists in modern medical practice stems from the activity of but a tiny fraction of one per cent of all doctors.

"Let us get to know our doctors and understand their problems," he said. "They are our stoutest ally in the struggle to preserve our American heritage."

Study In-Hospital Liability Problems

SAN FRANCISCO—In-hospital medical professional liability problems are the subject of special study and activity by a joint committee of the A. M. A. and the American Hospital Association.

In February, 1959 the committee proposes to spell out its recommendations concerning the appointment and operation of joint professional liability committees at the state and local level. At the same time, it will release a joint film on professional liability problems.

WAUPUN—Beautifully landscaped, the new Waupun Clinic is the pride of Drs. Jack A. Peterson, Harmon H. Hull and C. P. Reslock. Facilities include a large lobby and business office, nine examination and consultation rooms, a minor surgery with a recovery room, a laboratory and drug room, an x-ray room, an area for B. M. R., electrocardiogram, diathermy, ultraviolet treatments, and a lounge. The structure is equipped with air conditioning, four-zone heating and hi-fi which serves the purpose of relaxation and reinforcing the soundproofing. There is ample parking area. (Lawrence Weksler Photo)

DR. SIMENSTAD NAMED TO HEAD NORTH CENTRAL CONFERENCE

MINNEAPOLIS—Dr. L. O. Simenstad, Osceola, a past president of the State Medical Society of Wisconsin, has been named president-elect of the North Central Medical Conference. He will take office in December, 1960.

The conference is composed of the officers of the state medical societies of Wisconsin, Iowa, Minnesota, Nebraska, North and South Dakota.

Dr. William T. Casper, Milwaukee, a member of the Wisconsin society's Commission on Medical Care Plans, told the conference at its annual meeting that non-medically controlled health care plans are of concern to the medical profession largely because they do not guarantee the preservation of the doctor-patient relationship. He said:

"Our biggest job is the task of convincing the union member and the plant manager, the college professor and the corn grower of one very fundamental fact—the patient will get the best medical care when his personal physician is free to offer his services with no strings attached."

A report on the efforts of psychologists to obtain certification was presented by **Dr. E. D. Schwade**, Milwaukee, chairman of the Wisconsin society's Division on Nervous and Mental Diseases.

"The psychiatrist looks on the field of psychology as a learned and highly essential part of the field of mental mechanics," Dr. Schwade said. "We feel that he has made many contributions in the area of mental processes without which the psychiatrist could not practice his profession.

"We need the psychologist to administer, interpret and evaluate psychological testing. His training prepares him to assist in this diagnosis, research and teaching in the field of human behavior.

"We want the psychologist on our team but we do not want him to treat mental illness since we feel he is in no way qualified to practice this branch of medicine."

Carl A. Tiffany, Chicago, actuary for the State Medical Society's prepaid plans, said Wisconsin Blue Shield is making two highly significant contributions to health insurance progress in the country:

1. With regard to pathology, radiology, anesthesiology and psychiatry, Wisconsin Physicians Service believes that prepaid plans should not be a bar to the medical profession solving the problem of the practice of medicine in these fields through hospitals. Neither should Blue Shield be a device for solving the problem. W. P. S. is gradually making available coverage for these medical services when they are performed by physicians in or out of hospitals.

2. W. P. S. is pioneering in providing benefits for physicians' services without the use of a fee schedule.

Compulsory National Health Insurance Could Happen Here, Executive Declares

MINNEAPOLIS—What is happening in Canada with that government's national hospital insurance scheme can also happen in the United States, delegates to the North Central Medical Conference were told.

Ardell T. Everett, Newark, N. J., an officer of the Prudential Life Insurance Co., said Americans should be aware of the insidious forces working to destroy voluntary health care.

He said that since provincial government plans were installed in Saskatchewan, British Columbia and Alberta, "which succumbed to the political doctrine of *free* health care," costs have risen, long waiting lists confront hospitals, and other woes of socialized plans have come to the front.

Everett said the unhappy experience is "not a ready-made deterrent to the expansion of this system in other parts of Canada. The contrary is true." He listed these reasons for the passage of federal hospital legislation in Canada:

1. It was deeply rooted in the political party platforms of Canada.
2. Three provinces were in financial trouble in their own hospital care systems.
3. Organized medicine did not resist it. The doctors were passive because they felt that opposition would lead to socialized medicine.
4. Most of the hospitals were in "acute" financial straits.
5. A strong political figure took this area of the platform as an individual charge of accomplishment.

"It seems inevitable that the medical profession will be involved in future legislation," Everett said, "for these reasons:"

1. It is politically attractive to offer *free* medical care to people.
2. As costs mount, the government will tend to blame the profession —since it is they who admit patients, determine discharge dates, and order diagnostic studies and treatment.

"Few, if any, congressmen will risk their political future by opposing the expansion of social security benefits," the insurance company executive declared.

". . . many legislators honestly feel they are voting in accordance with the wishes of their constituents, paying little heed to the ultimate financial impact on the total economy of the country.

"You can be sure that the principles of the Forand bill were not defeated—only tabled! Next year, and especially in 1960, you can expect renewed efforts to take this very major step toward compulsory health insurance. Here's what must be done:

"1. The benefits and availability of voluntary health insurance must be expanded.

"2. The cost of health care must be controlled to the point that any increase can be justified to the public.

"3. Relationships between insurers and the providers of services must be improved in the many areas of mutual interest.

"4. The public must be informed as to the advantages of voluntary health care and the dangers and cost of compulsory national health insurance."

Health insurance, be it service or indemnity, and medicine are inseparably bound together in the American free enterprise system, he said.

OUTLINE WAYS TO EXPEDITE DISABILITY PAYMENTS

WASHINGTON, D.C.—The best way to speed payment of disability payments under the social security law is to prepare complete medical reports.

The U. S. Department of Health, Education and Welfare, the Social Security Administration and the Bureau of Old-Age and Survivors Insurance agree that by compiling comprehensive specific clinical data, members of the medical team can perform a great service for patients, and also save their own time.

Under the Social Security disability provisions, monthly benefits may be paid to disabled workers aged 50 to 65, and also, regardless of age, to the dependent disabled sons and daughters of workers who have retired or died.

Disabled workers under 50 may have their social security records "frozen" to protect their own and their families' rights to future benefits.

The process goes like this:

Disabled persons apply for these benefits or to have their records frozen at their nearest social security district offices. Each office is prepared to give the application information about his rights, helps him fill out his application, and to get the proofs and documents he may need to support that application. Very necessary is medical evidence showing the extent of his disability. This he is required to obtain at his own expense.

His Social Security office supplies medical report forms on which this medical evidence can be outlined. Several medical reports may be supplied for evidence from more than one physician, hospital, institution etc., where he has been treated for his disabling condition.

The form lists the kind of medical facts needed to reach a decision as to whether the patient's impairment is severe enough to meet the official definition of "disability" in the social security law.

However—the use of the form is not mandatory. A narrative summary on the doctor's stationery may be given, if preferred. Or it may be forwarded on a form used by the hospital, institution or agency. Photocopies of pertinent records are acceptable, too.

Whatever form is used, it must be sent to the social security office when completed. It should give the history, symptomatology, clinical findings and diagnosis in sufficient detail to permit another physician, who will not examine the patient personally, to arrive at a realistic evaluation of the patient's remaining capacity for work.

Sometimes this may call for more detailed medical data than the physician has needed for his diagnosis or treatment of the patient's condition. In the management of a heart patient, for example, such general terms as mild, moderate or severe are of much significance. But more precise data is needed to measure the extent of cardiac pathology in determining disability for employment. This should include cardiac size as shown by x-ray or clinical examination, EKG findings, cardiac edema, the amount of dyspnea or angina, described in terms of the number of steps that can be mounted or distance in feet or blocks that the patient can walk, the extent of renal involvement, response to therapy, etc.

It should be noted that the attending physician is asked only to provide this type of objective data. He is not put in a position of having to determine whether his patient is "disabled" under terms of the Social Security law.

This decision, in terms of severity of impairment, work capacity of the patient, employment potential, is made by a review team in an agency of the state in which the applicant resides.

In Wisconsin, the rehabilitation division of the State Board of Vocational and Adult Education works under an agreement with the federal government. In Wisconsin, each "team" consists of an M.D. and a member of the division staff who is classified as a case supervisor-disability examiner, and is trained in evaluating the personal and vocational aspects of disability, such as age, education and work experience.

The Wisconsin division has five medical consultants participating in these determinations. Four of these consultants are internists. Periodically, these physicians and representatives of the division meet with the State Medical Society's Division on Rehabilitation, the advisory body for the team.

The determinations of disability made by the state teams are reviewed by professional personnel in the Bureau of Old-Age and Survivors Insurance . . . personnel trained in evaluating the medical and legal aspects of disability.

Harrisburg Blue Cross Reports Loss

HARRISBURG, PA.—Losses of almost $900,000 in the first four months of 1958 were reported by the Harrisburg Blue Cross. Increased rates went into effect June 1.

INCOME PROTECTION INSURANCE

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TIME HEALTH POLICIES

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MILWAUKEE WISCONSIN

SUMMARY REPORT: SPECIAL SESSION OF THE HOUSE

MADISON—The following recommendations and resolutions were adopted by the House of Delegates of the State Medical Society at its special meeting in Stevens Point Sept. 28:

RESOLUTION INTRODUCED BY DANE COUNTY MEDICAL SOCIETY DELEGATES

Whereas, considerable effort to arbitrate the differences between Surgical Care of the Medical Society of Milwaukee County and Wisconsin Physicians Service of the State Medical Society of Wisconsin has failed, and

Whereas, the effect of these differences has been to confuse the patient, the hospital, the physician and others in a manner detrimental to both plans, and

Whereas, research continuing the pioneering efforts of Blue Shield is vital to the cause of prepaid medical care as indicated by the successful pilot study of the "No Fee Schedule Plan," which is expected to replace to an appreciable degree plans predicated on fixed benefits, and

Whereas, successful operation of a prepaid medical care plan of the "No Fee Schedule" order is predicated upon the ability to accommodate such plan to variable local circumstances and such accommodation can only be achieved by the administrative direction of the concerned constituent medical society of the State Medical Society of Wisconsin in an anticipated progressively increasing exercise of "home rule;"

Now, Therefore, Be It Resolved

1. That this House of Delegates at this meeting establish by vote one Blue Shield Plan to serve the State of Wisconsin under the direction of the House of Delegates of the State Medical Society of Wisconsin, and

2. That in deference to "home rule," any county society unit may operate a branch of the mother plan within that county society's geographical limits and under the direction of the majority of the physicians practicing within those geographic limits, and

3. That exclusive franchise to represent Blue Shield in any geographic area shall be granted at the discretion of the House of Delegates of the State Medical Society of Wisconsin.

* * *

LEGISLATION

In a special report to the House of Delegates in 1938 of the Special Committee to Study Hospital Insurance, upon which there were physicians, hospital administrators, and others, the House received and approved a statement that *"a hospital insurance plan is and properly should be subject to the regulation of the insurance department of the state. The thousands of people who will pay into a group hospital fund, in expectation of receiving hospital care if sick, are as much entitled to protection by the state as are persons who pay premiums to an insurance company in the expectation of receiving any other indemnity in case of loss, depending upon the type of insurance. The welfare of a great mass of people is no different in either case."*

In the initiation of hospital service plans and of medical service plans the plea was made that they be exempt from virtually all insurance department supervision. Such was not the position of the State Medical Society of Wisconsin. Such plea, however, was accepted by the Wisconsin Legislature.

The development and acceptance of voluntary health plans in Wisconsin during the past decade has been little short of phenomenal. The purchase of this type of protection has become accepted as one of the practical necessities of regular budgeting by a substantial majority of the households of the country.

If the privileged status of exemption from all but a very few provisions of the insurance code was warranted at the time of planning and development of these programs, it was because they were venturing in a relatively uncharted area.

The Council will conduct a special study of this subject to the end that minimal legislation be supported in the 1959 session of the legislature which will assure sufficient supervision of these plans that their impact on the economic aspects of health care may be carefully guarded.

* * *

STUDY OF HOSPITAL INSURANCE

The Council recommends that . . .

Since officials of Associated Hospital Service (Blue Cross) have stated their disinterest in sparsely settled areas of the state . . .

Since the current policy of Blue Cross provides varying benefit payments to hospitals in various areas of the state, although the rates charged subscribers are essentially the same . . .

Since it appears that the operations of Blue Cross are not only chiefly metropolitan in character, but, consequently, directed and influenced by metropolitan hospitals . . .

Since the record of Blue Cross has been one of consistent rate increases which, while doubtless justified, may be caused more by metropolitan areas than the less densely settled areas of the state . . .

Since published reports of Blue Cross for 1958 show consistent monthly losses, with the inevitable consequence that further rate increases are indicated in the near future . . .

Since the State Medical Society of Wisconsin and the two hospital associations in Wisconsin stood sponsors of the law under which Blue Cross exists in this state. . .

Since this program grew out of a special study by the State Medical Society in 1937–38 . . .

A special committee to study hospital insurance be created in the image of the 1937–38 committee, which represented the various hospital interests in this state as well as the State Medical Society; that such committee be appropriately financed and instructed to engage in a special study considering such ways and means as may exist to solve some of the hospital economic

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HOUSE . . .

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problems confronting the people in the more sparsely settled areas of the state; to examine current policies with a view to determining ways and means of controlling misuse to the detriment of all concerned; to examine into the bargaining mechanisms between hospitals and Blue Cross, and to offer its recommendations to an ensuing session of this House of Delegates upon these and such other points as may be deemed valid to its study, including the question of whether the public convenience, need, and economy would be served by the organization of a second Blue Cross program which, while operating of necessity throughout the state, would concentrate its efforts principally outside of Milwaukee County.

If this recommendation is approved by the House of Delegates, the Council will proceed forthwith to the development of such a study and will seek the cooperation of its Charitable, Educational, and Scientific Foundation which has already accumulated over $10,000 for the purpose of studying the costs and the possible control of costs of hospitalization. The Council will direct a further appropriation to that foundation and will ask that the foundation seek contributions from other interested parties to the end that the study will be detailed and implemented with the skillful assistance of actuaries, accountants, attorneys and lay advisors representing the subscribing public especially interested in this area.

* * *

AMEND BY-LAWS

Every county medical society is directed to amend its bylaws to the end that it will conduct no functioning operation within the territorial jurisdiction of another county medical society unless with the formal consent of that society and with the approval of the State Medical Society.

If this is not voluntarily accomplished and made effective by the end of 1958, and retroactive as to any existing program in violation of territorial jurisdiction, the Council will, under the provisions of Chapter VI, Section 4, recommend to the 1959 session of the House of Delegates that the charter of such county medical society be forthwith revoked and immediate efforts made to reorganize such county society so that it conforms to Chapter 148 of the Wisconsin Statutes.

The Council will, prior to making any such recommendation to the House of Delegates, conduct conferences or call special meetings with members of such county medical societies to the end that democratic membership activity may supplant autocratic officialdom, if such appears necessary.

* * *

FAIR ADVERTISING

The Council determines that the use by The Medical Society of Milwaukee County and by Associated Hospital Service (Blue Cross) of the symbol and term "Blue Shield" in all counties of the state where it has been used to identify Wisconsin Physicians Service for more than 10 years is producing both professional and public confusion, appears to be misleading to the purchaser, and is destructive of the very objective of promoting the symbol and name as indicative of doctors' plans working in harmonious effort.

The Council asks that the House of Delegates approve its contemplated action of presenting such usage to the insurance department in Wisconsin to determine whether the same is not in violation of fair and ethical advertising standards self-imposed upon the insurance industry.

* * *

ALLOCATION OF COSTS

The costs of determining policy and procedure in the current administrative problems with Blue Cross–HIC–Surgical Care have not been inconsiderable.

Special meetings of the Council, the Commission on Medical Care Plans and of this House have been necessitated. Consultants have been retained. Staff overtime, travel and other costs have been incurred.

The Council believes that these costs are properly those of the society and should not in any part be borne by subscribers to Wisconsin Physicians Service. These individuals have paid their premiums to secure the benefits of the plan, not to contribute to the financing of inter-plan controversy of the character being considered by this House.

The Council has, therefore, directed these costs to be charged dues and related income. It has also directed the society's independent certified public accountants to review all internal accounting procedures to that end and to provide a special report for consideration by the delegates in May of 1959.

* * *

A STATEMENT OF POLICY

By the Council of the State Medical Society of Wisconsin to the Special Session of the House of Delegates

In prior years this Society, acting through the House of Delegates, has both approved Blue Cross of Wisconsin and commended it for successful promotion of hospital costs protection.

At the present time the State Medical Society of Wisconsin, much against its wishes and its intent, finds itself in public debate with Blue Cross, with Health Insurance Corporation, its stock-for-profit insurance company, and with its activity in promoting a county society plan competitive to Wisconsin Physicians Service but using the same trade name and symbol of "Blue Shield."

It was the earnest desire and active endeavor of the State Medical Society to avoid these developments. It felt that its plan, Wisconsin Physicians Service, and Blue Cross could stand in public association without requiring either to be subject to domination or control by, or necessarily under contract with, the other.

It is fruitless now to recount all the details which led to administrative parting of the ways between the State Medical Society of Wisconsin and Blue Cross. The society had developed a new program, the Special Service contract, which required field and sales servicing of a character which Blue Cross, in the society's judgment, was unable to supply. The society therefore proposed its own servicing staff, with certain internal operations delegated to Blue Cross.

Late in 1956, Blue Cross had initiated a demand for an increased rate of compensation from the State Medical Society which the society felt uneconomical and unreasonable. It was the inherent right of the society, as the owner and operator of Wisconsin Physicians Service, to deny that request

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HOUSE . . .

(Continued from page 83)

which, while subsequently lowered, was never withdrawn by Blue Cross.

This impasse led to ultimate administrative separation of the plans. This was a mutual responsibility and not, as some Blue Cross personnel have said, solely a responsibility of the State Medical Society of Wisconsin.

It was likewise the sincere endeavor of the society to avoid these developments. But they came about.

Consistent with the society's position that both plans could stand in public association, the House of Delegates in May, 1958, adopted a resolution seeking just that, and inviting the hospitals of Wisconsin to cooperate to that end.

Within a few days, however, Blue Cross of Wisconsin, a nonprofit organization, rejected this invitation and put into operation a stock-for-profit insurance company, solely owned and controlled by it, to engage in the sale of surgical-medical policies.

Apparently in fear that the Blue Cross insurance company threatened the existence of this plan, Surgical Care, (although it had assurances to the contrary from Blue Cross,) The Medical Society of Milwaukee County, by action of its board of directors, first entered into 10 counties which it considered part of metropolitan Milwaukee, and then, shortly afterwards, entered into the entire state. These are regrettable circumstances. Domination and fear were judgment considerations rather than public welfare, reason, and diplomacy.

The State Medical Society of Wisconsin—faced with the fact that Blue Cross-Surgical Care-HIC were endeavoring to switch installations of the State Medical Society to their several programs, and in the process were attacking the adequacy and stability of the plan of the State Medical Society —had no alternative but to establish its own hospital costs protection.

In doing so, it endeavored to create a "contribution" to this field, as well as a contract. It believes it has done just that. Its program is related to the costs of hospitalization in the various areas of the state and does not blend metropolitan costs with those of rural areas.

We deeply regret the circumstances forced upon us by the Blue Cross-Surgical Care-HIC alliance.

Segments of the public perhaps will now consider the State Medical Society in opposition to the principal objectives of Blue Cross, when the fact is that the society endorses the principle of free enterprise and, in common with the American Medical Association, asserts that "The Voluntary Way is the American Way."

This position precludes the endorsement of but one approach to insuring against the costs of illness.

We are at odds with Blue Cross-Surgical Care-HIC on administrative and interplan philosophy.

We favor adequate insurance against the costs of illness, which should be their principal objective, rather than their current efforts to destroy the programs of the State Medical Society in pursuit of the same objective.

Our major concern is not size, but sufficient freedom and opportunity for the society to continue its well-established leadership in this movement.

Despite the brazen unfairness, which should be terminated once and for all, of a county medical society joining in an effort to discredit and destroy the State Medical Society plan, and despite the most amoral of competitive approaches on the part of both Milwaukee plans in turning physician against physician, we can now report to the House of Delegates that the tide is turning.

As it must be clear to all reasonable men, the ultimate issue is one of moral courage and of responsible conduct, and with the conviction that right grows out of justice and not out of financial might, your Council stands firm in its conclusion that WISCONSIN PHYSICIANS SERVICE will continue in this state and among all plans as one conceived with the best interests of the people at heart.

We subscribe again to the statement . . .

"GIVE LIGHT AND THE PEOPLE WILL FIND THE WAY."

* * *

REPORT OF THE REFERENCE COMMITTEE ON RESOLUTIONS

At the request of the House of Delegates the committee had further hearings and studied the testimony submitted to it and has the following recommendations:

(1) That the Dane County resolution be adopted.

(2) That the resolution submitted by the Sixth Councilor District, and its amendment by Dr. E. J. Nordby, not be adopted since the material is adequately covered by the foregoing resolution and the recommendations of the Council.

(3) Dr. J. W. Fons' excellent suggestion of utilizing a lay committee to compromise the differences between the two Blue Shield plans does not seem essential at this time in view of the recommendations above.

(4) The reference committee has studied the recommendations of the Council and recommends approval by the House of number one as submitted.

(5) The reference committee has considered recommendation number two of the Council, and while it feels that some of the allegations can be questioned, it agrees with the desirability of the study as outlined with the addition that lay advisors representing the subscribing public also be included.

(6) Your reference committee has considered Council recommendation number three and recommends its adoption.

(7) Your reference committee recommends approval of Council recommendation number four except that the words "insurance department" be inserted in place of "public officials."

(8) As to Council recommendation number five, the reference committee feels it cannot be considered because it is in conflict with the constitution and bylaws.

(9) Your reference committee recommends that the statement of the Council regarding costs related to the current problem which has necessitated this special session of the House of Delegates be accepted.

(10) Your reference committee has read the statement of policy submitted by the Council yesterday and has no recommendation concerning it.

Mr. Speaker, I move adoption of this report.

E. D. Sorenson, M.D.
Chairman
P. H. Gutzler, M.D.
R. W. Mason, M.D.
C. J. Picard, M.D.
D. M. Willson, M.D.

600 CRIPPLED PERSONS CAMP ANNUALLY AT WAWBEEK

Wisconsin Easter Seal Society Supports Project

WISCONSIN DELLS—Wawbeek is an Indian word for "great rock," and to some 7,000 crippled persons who have camped here since 1938, the term has special significance.

Cerebral palsy victims, and children and adults (to age 45) with polio, injuries, muscular dystrophy, congenital malformations, multiple sclerosis, arthritis, spina, bifida, amputations and tuberculosis of the bone have spent part of their summers at this Wisconsin Easter Seal Society enterprise, located just a half mile from this resort community.

Despite crutches, braces and wheelchairs, most crippled campers enjoy fun-filled sessions of swimming, fishing, hiking, picnics, archery, arts and crafts and other outdoor activities carefully adapted to their individual capabilities.

Selected by county Easter Seal societies, physicians, nurses, social workers and others, the campers come from all over Wisconsin. Their supervision and safety are taken care of by a staff of 35, including a registered nurse, teachers and social workers.

Drs. John H. Houghton and C. F. Broderick, and other members of the Dells Clinic are on call to come to Camp Wawbeek. When necessarry, hospital facilities at Baraboo and Portage are used.

Orthopedically-handicapped individuals having a history of convulsive disorders may be referred, providing their applications are accompanied by a physician's statement indicating that seizures are under control. Campers with only slight disabilities may be referred, providing there is a particular reason for their needing the group experience.

The camper's mentality, officials said, should be such that he can profit from and enjoy the experience without making unreasonable demands on the staff or other campers. Because of the nature of the camp program, it is not possible to accept rheumatic fever patients, those with congenital heart or other cardiac conditions.

In order to avoid risk of communicable diseases being brought to camp and to provide adequate medical information and instruction, all campers must bring a medical report completed by a physician within three days before arrival at camp.

ONE OF THE BIG FEATURES of Camp Wawbeek, Wisconsin Dells, is the swimming pool, dedicated in July, 1957, and almost always filled with adults and children alike at the Wisconsin Easter Seal Society camp. The pool was financed largely by contributions from Kiwanis clubs and other service organizations. Wheel chairs, braces and crutches are a familiar pool-side sight, and there are special ramps for easy access to the water, a "roll-out" type deck, large patio, special walks, steps and hand rails.

The fee for every camper is $56 for a 13-day period. This is about half the cost, the remainder being paid by the Wisconsin Easter Seal Society. Sometimes the $56 is paid by county societies or other sponsors.

Facilities at the camp include boys and girls' dormitories, a swimming pool, dining hall, craft shop, administration building, director's office, storage area, guest house, nurse's office and the "castle," an old home converted into recreational facilities and rooms for counsellors.

Every year the camp is host to the Cerebral Palsy Parent–Training Institute. Approximately 20 youngsters, under six, and their mothers are selected by the staff of the Cerebral Palsy Center of

(Continued on page 88)

PROFESSIONAL BUSINESS SERVICE
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Urge Revisions in Hospital Planning

SAN FRANCISCO—Substantial revision in the Hill–Burton hospital survey and construction program was recommended by the American Medical Association.

The House of Delegates, meeting here in June, approved a report of the Council on Medical Service of the A.M.A. reviewing the Hill–Burton hospital program since its inception in 1946.

The A.M.A. made eight recommendations:

1. **The Hill–Burton program should be continued although its objectives should be redefined and certain changes made to render it more effective. Since the major object of bringing hospitals to rural areas has largely been achieved, emphasis now needs to be directed to modernization, renovation and remodeling of existing hospitals and the construction of facilities in suburban fringes of metropolitan areas.**
2. States should be permitted to establish priorities in accordance with their individual needs.
3. All categorical grants should be eliminated permitting the states to allocate funds to the various types of hospital and medical facilities according to their needs.
4. **The term "diagnostic or treatment center" should be eliminated from any listings in the Hill–Burton Act. The A.M.A. report said that there is little evidence of a need or demand for special provisions to build diagnostic or treatment centers. Moreover, it said, the definition of the term is vague and there is much confusion as to what it means.**
5. The term "public health center" should be eliminated from any listings in the act. The A.M.A. report said most states have provided for public health center construction through appropriate local and state tax resources and it is doubtful that continued emphasis for the benefit of a few states is justified.
6. **Programs should be established to provide for federally guaranteed long-term loans at low interest rates for the construction or renovation of hospitals and nursings homes.**
7. The surgeon general should be requested to appoint a physician in private practice as a member of the Federal Hospital Council, this physician to be selected from a list submitted by the A.M.A. To date such representation has not been accorded to the medical profession.
8. **Each state medical association should take steps to obtain adequate representation on its own state hospital advisory council. The A.M.A. report declared that the proposed changes provide for greater freedom to the states and more active participation by the medical profession.**

The full report of the A.M.A. on the Hill–Burton program is available for interested persons upon request to the State Medical Society.

Voice Opposition To S–S Amendments

NEW YORK—The Health Insurance Association of America has taken a strong stand against hospital and medical benefits under social security.

The association said the proposed social security amendments would not solve the immediate problem of helping the presently aged who cannot meet their health care costs, would increase social security taxes to unreasonably high levels, and would represent a major departure from the original concepts of social security.

Buffer Fund

OASI is a system under which the active workers and their employers are contributing the taxes necessary to pay benefits to their fellow citizens on the benefit rolls. The active workers now covered under the system must look for their own old-age benefits, not in any large measure to the Trust Fund, which is only a moderate buffer fund to cover temporary excess of benefit payments over tax receipts, but mainly to the willingness of the next generation of active workers to pay the increased taxes out of which the retirement benefits will come.

Push Fight Against Food Faddism, Quackery

CHICAGO—As part of a concerted program to inform the public of the dangers of food faddism, the A. M. A. has issued a campaign kit for officers of county medical societies.

Joining the A. M. A. in the campaign are the Food and Drug Administration and the National Better Business Bureau. They seek the aid of county medical societies in exposing the racket costing Americans over 500 million dollars every year.

The kit contains program ideas, a sample speech, a list of available films on the subject, pamphlets, reprints and research materials.

Kits may be ordered from the State Medical Society, Box 1109, Madison 1, Wis., or through the A. M. A. Communications Division in Chicago.

Swanberg Plan Aids Scholars

QUINCY, ILL.—To motivate talented youth to seek a college education, the Swanberg Medical Foundation of the Adams County Medical Society is honoring outstanding high school seniors in its area.

The program calls for encouraging the young people to prepare for college while in high school, to work for good grades, and then continue on in college on the same high level of achievement.

Awards include money, certificates of achievement and gold keys.

Dr. Harold Swanberg, foundation secretary, said his society expects the plan to combat today's so-called "crisis in education." He said there is a tendency to promote sports and extra-curricular activities at the expense of scholarship.

The foundation also conducted a guidance counseling workshop for high school teachers this past summer.

Other county medical societies were invited to write for details, and to initiate similar programs, not only to aid the youths but to improve local public relations.

Medical Care Expanding in County Homes

MADISON—More and more residents of Wisconsin's county homes are requiring medical and nursing care, according to a special report of the State Department of Public Welfare.

The report, filed by Wilbur J. Schmidt, department director, covered the months of April, May and June, 1958. Twenty-seven county homes are approved as public medical institutions.

In 1950, about 60 per cent of county home patients were capable of self-care and 40 per cent required care of some degree. Now the situation is reversed, with only 40 per cent capable of self-care and 60 per cent needing medical attention.

More than 1,100 of the 3,850 patients are bed or chair-fast, compared with 500 thus handicapped in 1950.

Mr. Schmidt said this big change toward accepting persons requiring more medical and nursing care was taken into account in planning new or remodeled institutions. Counties were advised to plan structures to enable them to care for the infirm. Two buildings being constructed in Bayfield and Polk counties are to be considered as nursing homes, and persons able to care for themselves will not be admitted.

Only two of the county homes do not have registered nurses in attendance, and these rely on physicians to provide professional care required and to direct the program carried on by practical nurses.

The present and future program calls for homes to include infirmary facilities to an increasing degree. It includes the application of new knowledge of the capacities of older persons to respond to physical medicine (including nursing care), reactivation and rehabilitative surgery.

The report stated that good nutrition "is found to be good business, and feeding people balanced diets of well prepared food in attractive surroundings is no longer regarded as catering to the whims of fussy old people."

Nineteen counties have constructed new homes, substantial additions or reconstructed old structures since 1950 to better meet the needs of the community and those of residents.

A new trend in the use of tuberculosis sanitariums as county homes and as county hospitals for chronic disease has developed.

Such sanitariums have been utilized in Eau Claire, Sheboygan, Racine, Dane and Outagamie counties, for the chronically ill.

Doctors Unite For Improved Sanitation Law

OMAHA, NEB.—A little pressure from physicians goes a long way toward clearing up a community health problem, the Omaha Douglas County Medical Society learned this year.

When a series of food poisoning cases pointed to improper handling of meat in city grocery stores, the society announced to local papers it was going to find out **"just what is lacking in our city and our health department to permit these outbreaks."**

What was lacking appeared to be an ordinance requiring inspection and licensing of groceries and meat markets, the only groups in the Omaha food industry not covered by sanitation standards.

What's more, the physicians found themselves in the middle of a battle between the city health department and the grocers' association. The grocers, it seemed, bitterly opposed an ordinance on the grounds that it would put too much power in the hands of the city health director.

The society, sticking to the role of impartial mediator and protector of community health, sent a team of doctors to inspect some stores. The chairman of the group told newspapers:

"We are not out to harm anyone. We are anxious to correct and help make Omaha a safe place for living."

After the inspection, the physicians agreed that an ordinance of some kind was necessary. This forced the grocers' hand. They drew up their own code to try for one year, after which the medical society will decide whether to campaign for a municipal ordinance.

SEEK $3,706,968 FOR HOSPITALS

MADISON—The State Board of Health has asked approval of federal grants-in-aid totaling $3,706,968 for hospitals and related facilities.

Funds were allocated tentatively to 22 projects which are being recommended for approval to the office of the Surgeon General, Public Health Service, U. S. Department of Health, Education and Welfare.

The federal funds are made available to Wisconsin for 1958–1959 under the Hill–Burton hospital construction program, and covers about 40 per cent of project costs.

After federal approval, construction must start before Aug. 1, 1959. The hospital projects (with number of beds, total cost and federal share, in that order):

Park Falls Hospital, 35 beds; $500,000; $200,000.

Medford Memorial Hospital, 50; $779,500; $311,800.

Door County Memorial Hospital, Sturgeon Bay, 50; $1,000,000; $400,000.

Memorial Community Hospital, Wautoma, 30; $320,000; $128,000.

Sauk–Prairie Memorial Hospital, Prairie du Sac, six; $40,000; $16,000.

Grantsburg Hospital, six; $300,000; $120,000.

Neillsville Memorial Hospital, 12; $190,700; $78,800.

Oconto Falls Community Memorial Hospital, 17; $202,500; $81,000.

St. Joseph's Hospital, Hartford, 31; $928,000; $110,800.

Burlington Memorial Hospital, 46; $1,310,315; $60,126.

St. Catherine's Hospital, Kenosha, 72; $1,450,000; $580,000.

West Allis Memorial Hospital, 250; $5,670,000; $500,000.

St. Mary's Hospital, Wausau, psychiatric unit, 25, $125,000; $50,000. Chronic disease unit, 30; $150,000; $60,000. Nursing school dormitory, 60; $325,000; $130,000.

St. Francis Hospital, La Crosse, psychiatric unit, 30; $572,000; $228,800.

Diagnostic and treatment center at Milwaukee Children's Hospital, $730,000; $132,039.

Nursing homes at the following:

(Continued on page 88)

WAWBEEK . . .

(Continued from page 85)

University Hospitals, Madison, to attend the one-week session.

Arranged to enligthen home care problems, to provide stimulating ideas to make the role of parents easier, and to make the children comfortable with others, outside the family circle, the institute takes in such subjects as toy making, importance of play, speech development, emotional factors, and forms of therapy. The children spend most of the day in nursery school classes.

The faculty this past summer included Drs. Henry I. Okagaki and Henry A. Peters, of the University of Wisconsin Medical School.

JOIN THE BOWLING PARTY!

MADISON—Here's your chance to sign up for the Wisconsin Doctors' Third Annual Bowling Tournament in Madison on Saturday, Feb. 7. Here's a chance for some real fun!

The tourney will be held at the Bowl–A–Vard Lanes on Madison's east side. Twenty alleys will keep things humming in fine style, starting at 9:30 a.m. with mixed doubles. After luncheon, there'll be two classes of men's singles, men's doubles, men's team event, and the auxiliary singles championship. After the rolling has finished, there'll be a cocktail party and dinner at the Edgewater Hotel.

All members of the State Medical Society are invited to roll 'em in this funfest. Prizes will be awarded top scores.

Be sure to send in the coupon below, filling in all necessary spaces. Be sure to write now for room reservations (the Edgewater is our headquarters).

Don't fret if your average isn't 200 per game. You will find a lot of others in your class, high, low, or middlin' . . . Don't miss this chance to take part in a big day of real sport. Send the coupon to Bowling, State Medical Society, Box 1109, Madison 1, Wis., as soon as possible!

YOU BET, I plan to be with you Feb. 7 in Madison at the Doctors' Bowling tournament at the Bowl–A–Vard Alleys.

My average is _____ per game.

Put me down for: _____ Men's Singles

_____ Men's Doubles

_____ Mixed Doubles

_____ Team (All members of one team must come from one county medical society).

My Lady plans to bowl in the Auxiliary Singles, too _____

_____
M.D.

_____
Street

_____
, Wisconsin

(please print, and thanks)

HOSPITALS . . .

(Continued from page 87)

St. Benedict's Hospital, Durand, 30; $311,452; $4,000. St. Joseph's Hospital, Hillsboro, 31; $344,600; $58,403. Holy Family Hospital, New Richmond, 20; $205,000; $4,000. Calumet Memorial Hospital, Chilton, 24; $150,000; $60,000. Sauk–Prairie Memorial Hospital, Prairie du Sac, 30; $158,000; $63,200.

Rehabilitation facilities at University Hospitals, Madison, $50,000; $20,000, and Luther Hospital, Eau Claire, 60 beds; $876,050; $250,000.

Chronic disease hospital unit at St. Vincent's Hospital, Green Bay, 52 beds; $150,000; $60,000.

Congress extended the hospital construction program for five years, beginning next July 1, to enable additional, high-priority communities to provide urgently needed facilities.

In 1958, requests for federal aid were received for 53 projects, seeking $16,727,309.

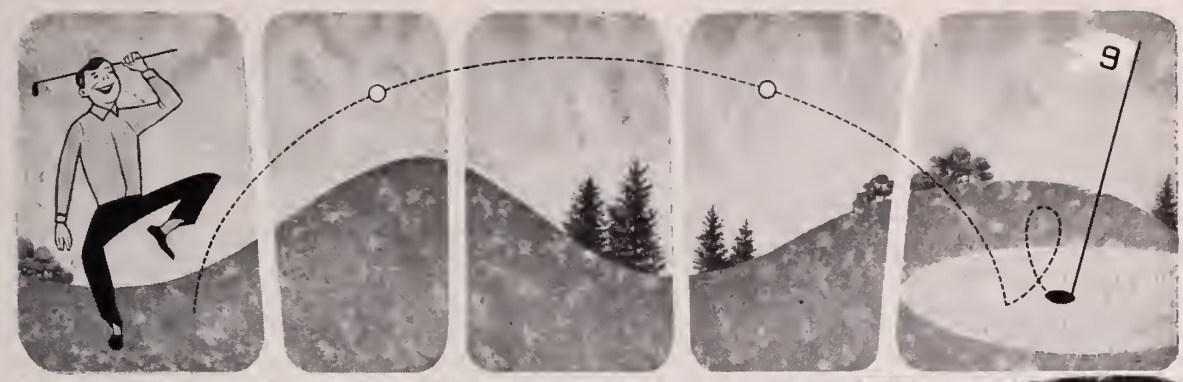
Report on Medicare Program

SAN FRANCISCO — Medicare, the government health care program for dependents of military personnel, has paid nearly $36,000,000 to physicians and over $35,000,000 to hospitals in the first 18 months of its operation.

This was the report from Major General Paul I. Robinson, the executive director of the Office for Dependent's Medical Care, Washington, D. C., to the American Medical Association meeting in San Francisco in June.

Significantly, Gen. Robinson said "in general the program has had excellent reception by the physicians in the nation. Evidence has been presented to substantiate the belief that the program is rendering medical care to those who could not reasonably obtain this service in hospitals of the uniformed services.

"The program, however, presents a distinct challenge to local medical associations in their own operational responsibilities in the areas of schedules of allowances and their utilization. It also presents a real challenge to the uniformed services medical services as a competitor for dependent patients."



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Dihydrocodeinone Bitartrate (Warning: May be habit-forming)	5 mg.	6.5 mg.
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Pyrilamine Maleate		12.5 mg.
Ammonium Chloride		60 mg.
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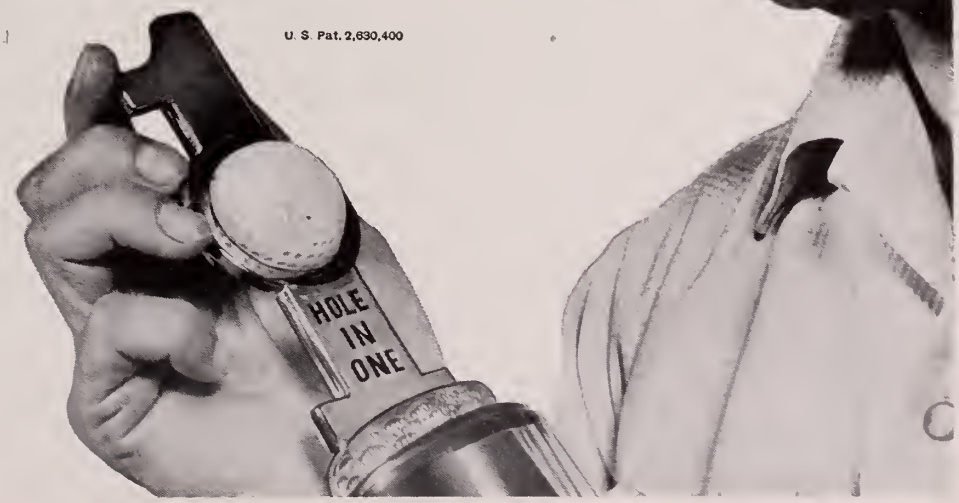

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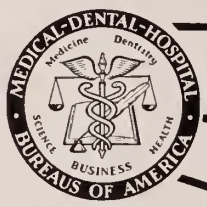

DOCTOR

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*Finnerty, F. A. Jr.: New York State J. Med. 57:2957 (Sept. 15) 1957.

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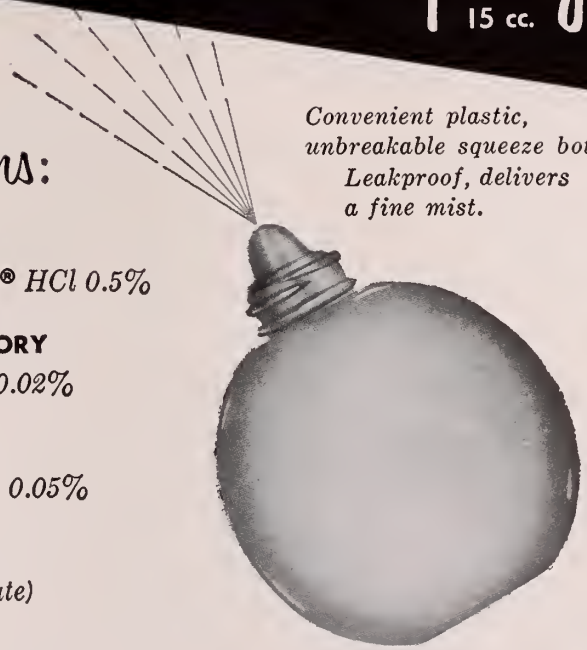

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American Board Review Course, Two Weeks, April 6
Blood Vessel Surgery, One Week, March 2

GYNCOLOGY & OBSTETRICS — Office & Operative Gynecology, Two Weeks, February 9
Vaginal Approach to Pelvic Surgery, One Week, November 17, February 2
General & Surgical Obstetrics, Two Weeks, February 23

MEDICINE—Electrocardiography, Two-Week Basic Course, March 16
Gastroscopy & Gastroenterology, Two Weeks, March 2
Board Review Course, One Week, April 20

DERMATOLOGY—Clinical & Didactic Course, Two Weeks, November 3

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OPENING FOR GENERAL PRACTITIONER: Clinic at St. Croix Falls, Wisconsin, needs a young G.P. for either locum tenens or permanent situation. Please call collect St. Croix Falls No. 251 or contact by letter Mr. K. R. Taylor, St. Croix Falls Clinic, St. Croix Falls, Wisconsin. 10–11

FOR SALE: Physician's complete office equipment, large office, reasonable rent, good active general practice grossing 30 to 35 thousand. Step in and start working. Five thousand for equipment (large x-ray machine, lab., two diathermy machines, large safe, surgical instruments, two sterilizers, Infra-red lamps, ultra violet, surgical spot lamps, cabinets, examination tables, office furniture, typewriter, adding machine, etc.) SPECIALIZING. Contact Box 757 in care of the Journal. m11tf

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WANTED: MEDICAL SPECIALIST for new building to open Jan. 1 at 1905 Monroe St., Madison. Rental space available on first floor, parking area, air conditioned and fire proof building. Contact William G. Healy, M.D., 1910 Monroe St., Madison, Wis. m11–12

WANTED: Young, married general physician to join well-established 2-man group in Northwest Wisconsin resort and farming community of 3,000, located in trade area of 25,000. New, completely equipped clinic building. New, fully accredited 26-bed, 8-bassinet hospital 4 blocks away. Excellent salary, with partnership in one year if mutually agreeable. Address replies to Box 751 in care of the Journal. p9–11

FOR SALE: Diathermy instruments, cabinets, examining and office furniture. May be seen Saturdays. Robert A. Turcott, M.D., Lake Mills, Wisconsin. m9–11

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FOR SALE: 30 MA portable x-ray machine in good condition—will demonstrate. Price $250. Address replies to R. E. Hunter, M.D., Argyle, Wis. m11–12

UROLOGIST, board eligible, 30, desires association with an already established Board certified Urologist or group. Contact J. C. Beltran, M.D., 8527 Kathleen Ave., Affton 23, St. Louis, Mo. 10–1

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RADIOLOGIST: For Capitol Hospital, Milwaukee, Wisconsin. Contact: Administrator, Capitol Hospital, 1971 West Capitol Drive, Hilltop 2–9100, Milwaukee 6, Wisconsin. 8tfn

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FOR SALE: Excellent location for a younger man, looking for a completely equipped clinic office setup. This is a going practice and money maker from the start. Will introduce. Any terms agreeable. Reason—moving West. Write Box 758 in care of the Journal. p11–12

WANTED GENERAL PRACTITIONER: Two young established general practitioners desire association of a third in a small northwestern Wisconsin town. Large medical and surgical practice. Immediate partnership to the right man. Contact Box 345, Grantsburg, Wisconsin. 10–12

ORTHOPEDIST: Wisconsin graduate, now associated with Class A Medical School, is interested in locating in Wisconsin. Board Member. Association with group of other Board member desired. Write Box 749 in care of the Journal. 11–1*

FOR SALE: Microtherm diathermy machine, three years old, used very little, like new, reasonable price. C. E. Siefert, M.D., 164 North Main Street, Oconto Falls, Wis., phone 9621. m11–12

THE PRACTICE OF A. F. RHEINECK, Suite 310, 2218 North Third Street, Milwaukee, Wisconsin, is immediately available to a qualified practitioner; equipment may also be purchased. All interested parties contact Attorney William E. Glassner, Jr., 2218 North Third Street, Milwaukee, Wisconsin, FRanklin 4–0790. p8,tf

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WANTED: Psychiatrists or young doctors interested in psychiatry to work at Mendota State Hospital. These positions are permanent and under Civil Service, salary depends upon previous experience and training. Housing available on grounds. Contact Dr. W. J. Urben, Superintendent, Madison 4, Wisconsin. 8–12

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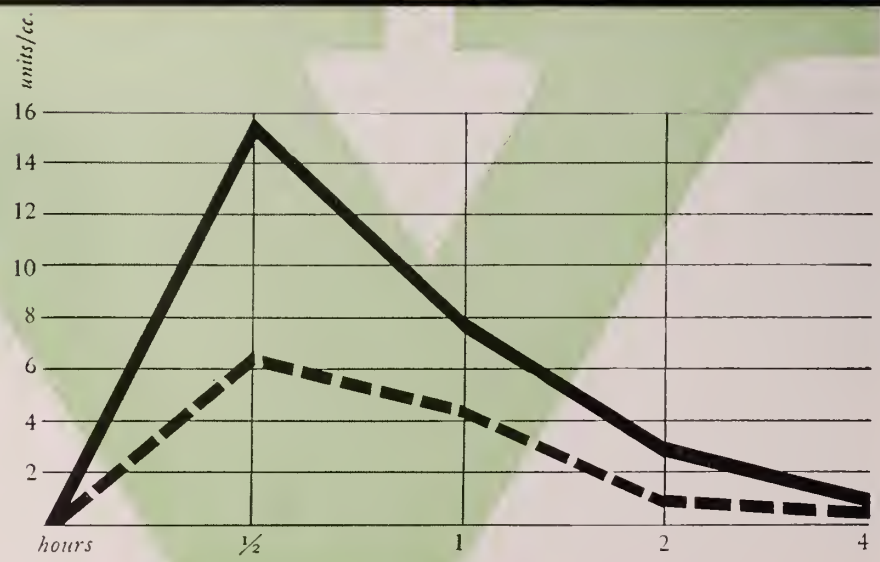

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Stephen E. Gavin, Fond du Lac, 1958

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List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland–Bayfield–Iron	H. V. Sandin 220 Seventh W., Asbland	C. A. Grand 520 W. Second, Ashland	
Barron–Washburn–Sawyer–Burnett	C. J. Strang Barron	H. M. Templeton Barron	Second Tuesday 7:30 p.m.
Brown	George Nadeau 128 E. Walnut, Green Bay	Frank Urban 305 E. Walnut, Green Bay	Second Thursday*
Calumet	J. M. Guthrie 302 Cleveland, Brillion	J. W. Knauf Chilton	
Chippewa	B. J. Haines Cadott	R. L. Hendrickson 12 Third, Cornell	Second Tuesday
Clark	T. N. Thompson, Jr. Neillsville	H. M. Braswell, Jr. Owen	
Columbia–Marquette–Adams	H. A. Winkler 115 W. Chestnut, Pardeeville	T. S. Westcott Pardeeville	Every Third Month 7:00 p.m.
Crawford	O. E. Satter Prairie du Chien	H. L. Shapiro Prairie du Chien	Third Wednesday
Dane	T. J. Nereim 3710 Spring Trail, Madison	A. P. Schoenenberger 122 W. Washington, Madison	Second Tuesday Sept. through June
Dodge	R. F. Boock 119½ Front, Beaver Dam	G. G. Drescher 106½ Front, Beaver Dam	Last Thursday*
Door–Kewaunee	J. F. March 413 4th, Algoma	A. S. Lanier 3rd & Ellis, Kewaunee	
Douglas	R. T. Anderson 1507 Tower, Superior	L. R. Rosin 2231 E. Fifth, Superior	First Wednesday** Hotel Superior
Eau Claire–Dunn–Pepin	D. M. Willison 314 E. Grand, Eau Claire	K. E. Walter 131 S. Barstow, Eau Claire	Last Monday
Fond du Lac	John C. McCullough 20 Forest, Fond du Lac	R. W. Schroeder 330 Ledgeview, Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley Wabeno	D. V. Moffet Crandon	
Grant	H. L. Doeringsfeld Platteville	H. W. Carey Lancaster	Last Thursday, March, June, Sept. and Nov.
Green	L. G. Kindschi 1770 13th, Monroe	J. A. Frantz Monroe Clinic, Monroe	

* Except June, July and August. ** Except July and August.

(Continued on next page)

List of Officers and Scheduled Meetings of County Medical Societies *(Continued)*

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Green Lake–Waushara	G. G. Mueller Princeton	J. C. Koch Berlin	Last Thursday, every other month starting in Jan.
Iowa	C. L. White Mineral Point	E. J. Hohler Mineral Point	First Thursday following first Monday
Jefferson	E. E. Burzynski 113 N. Third, Watertown	(Correspondence to President)	Third Thursday°
Juneau	J. H. Vedner Mauston	J. S. Hess Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	W. C. Kleinpell 723 58th, Kenosha	Mr. L. F. Jost, Ex. Sec. Box 669, Kenosha	First Thursday° Elks Club
La Crosse	F. J. Gallagher 630 S. Tenth, La Crosse	J. B. Durst 1707 Main, La Crosse	Third Monday
Lafayette	R. E. Hunter Argyle	N. A. McGreane 123 E. Ann, Darlington	Last Tuesday
Langlade	R. W. Cromer 824½ Fifth, Antigo	J. E. Garritty Antigo	First Monday
Lincoln	F. C. Lane 401 W. Main, Merrill	J. D. Millenbah 121 S. Mill, Merrill	
Manitowoc	J. W. Steckbauer Suite 304, Savings Bank Building, Manitowoc	D. A. Kuljis 1606 Washington Two Rivers	Last Thursday
Marathon	J. V. Flannery 808 Third, Wausau	R. B. Larsen 510½ Third, Wausau	
Marinette–Florence	Clarence H. Boren 1510 Main, Marinette	K. G. Pinegar 516 Houston, Marinette	Third Wednesday St. Joseph's Hospital
Milwaukee	S. A. Morton 3321 N. Maryland Milwaukee	L. R. Schweiger 324 E. Wisconsin Mr. J. O. Kelley, Ex. Sec. 756 N. Milwaukee, Milwaukee	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	H. A. Aageson 1113 Main, Oconto	C. E. Siefert Oconto Falls	
Oneida–Vilas	W. K. Simmons 1020 Kabel, Rhinelander	Marvin Wright 1020 Kabel, Rhinelander	Monthly
Outagamie	George A. Behnke 240 W. Wisconsin, Kaukauna	George A. French 601 W. College, Appleton	Third Thursday° Elks Club
Pierce–St. Croix	P. S. Haskins River Falls	P. H. Gutzler River Falls	Third Tuesday
Polk	Stella I. Burdette Balsam Lake	L. J. Weller Osceola	Third Thursday 7:00 p.m.
Portage	W. C. Sheehan 755 Strongs, Stevens Point	W. A. Gramowski 319½ Main, Stevens Point	
Price–Taylor	W. W. Meyer 410 S. Second, Medford	J. J. Leahy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
Racine	L. M. Lifschutz 816 16th, Racine	W. H. Williamson 1101 Grand, Racine	Third Thursday
Richland	George Parke 323 S. Central Richland Center	L. M. Pippin Richland Center	First Tuesday Richland Hospital
Rock	V. S. Falk 5 W. Rollin, Edgerton	E. S. Hartlaub 2020 Milwaukee, Janesville	Fourth Tuesday
Rusk	M. L. Whalen Bruce	H. F. Pagel Ladysmith	First Tuesday
Sauk	M. F. Huth 203 Fourth, Baraboo	J. J. Rouse Reedsburg	Second Tuesday°
Shawano	L. W. Peterson Shawano	A. J. Sebesta Shawano	Third Tuesday
Sheboygan	J. A. Russell Random Lake	R. M. Senty 1011 N. Eighth, Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	D. S. Sharp 140 E. Main, Mondovi	J. H. Noble 912 Harrison Black River Falls	Fourth Tuesday
Vernon	H. E. Oppert 318 S. Main, Viroqua	R. A. Starr Viroqua	Last Wednesday
Walworth	J. B. Schrock Sharon	W. C. Woods 607 Walworth, Delavan	Second Thursday°
Washington–Ozaukee	J. F. Walsh 125 E. Main, Port Washington	V. V. Quandt 57 S. Main, Hartford	Fourth Thursday
Waukesha	James V. Bolger, Jr. 102 E. Main, Waukesha	Philip Wilkinson 618 W. La Belle, Oconomowoc	First Wednesday
Waupaca	Owen Larson Clintonville	H. S. Caskey Clintonville	
Winnebago	P. S. Emrich 456 Mt. Vernon, Oshkosh	G. B. Hildebrand 59 Racine, Menasha	First Thursday
Wood	W. L. Nelson 480 E. Grand Wisconsin Rapids	J. R. Heersma 650 S. Central, Marshfield	Four times a year

° Except June, July and August.

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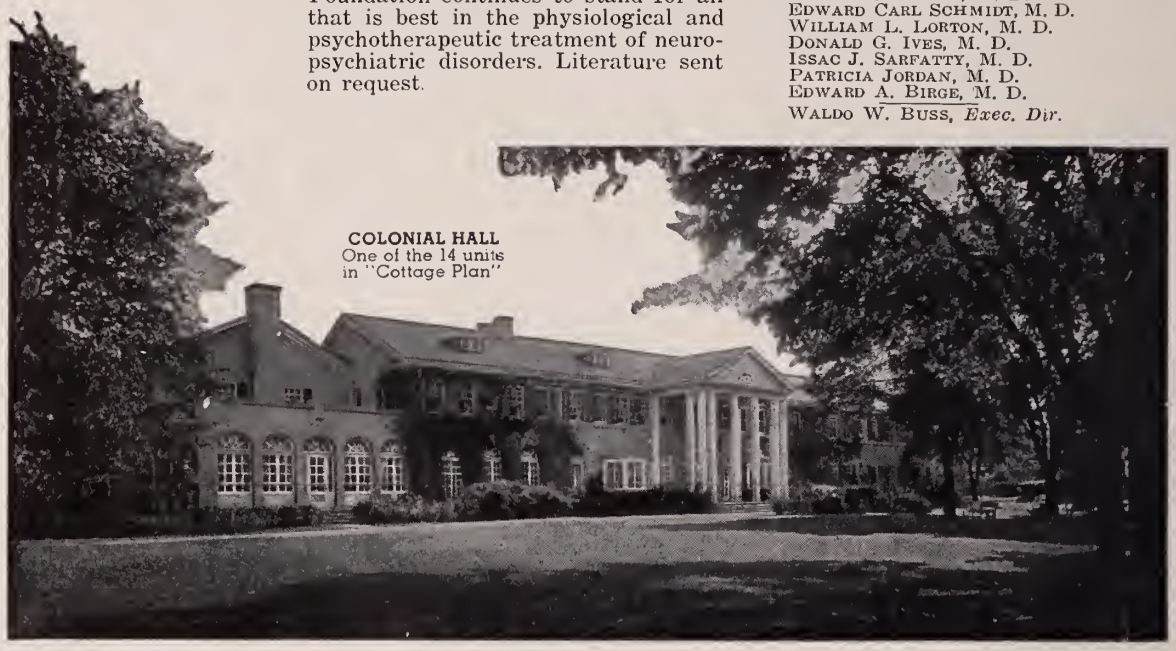

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Unconscious and Abortive Aspects of Pseudocyesis

By EMIL J. PAWLOWSKI, M. D., and MARGARET M. F. PAWLOWSKI, M. D.
Wakefield, Mass.

THIS case of pseudocyesis displays two very interesting features which to the authors' knowledge have not been illustrated previously. The first concerns the unconscious phase of the condition in which the patient is still unaware of her plight, and which constitutes a diagnostic problem. The other deals with the abortive aspects of pseudocyesis from which we speculate that the incidence of the disease is decreasing, and that in the future it will prove to be a "dying" entity.

Case Presentation

The patient, a 26-year-old, married, white woman, experienced four episodes of the abortive type of pseudocyesis in the same year. Each consisted in the following symptoms and signs: abdominal swelling lasting from one to three weeks, preventing the patient from buttoning her dress at the waist during the third and longest event; nausea, with sour eructations and regurgitation of liquid, but no real vomiting; a capricious appetite, resulting in a ten-pound weight gain during the third episode; constipation; and low back pain. Minimal ankle, wrist, and periorbital edema were present during the latter two occurrences. There was no amenorrhea or breast changes.

The second episode occurred two months after the first and the others were spaced four months apart. The patient was seen by her private physician on each occasion, and, in addition, she was examined by several house physicians in a hospital emergency room at the time of the first and last events. She had not suspected herself pregnant on any of these occasions. Routine history revealed nothing unusual about her menarche or menstruation. System review disclosed that for several years the patient experienced not infrequent periods of syncope preceded by frontal headache, profuse perspiration, generalized tremulousness, palpitations of the heart, and hyperventilation. Physical examination, including pelvic, was recorded by all observers as being within normal limits. Anxiety reaction and hysteria were suggested by the patient's private physician and one of the house physicians; however, the diagnosis of pseudocyesis was not entertained until after a psychiatric interview which was carried out during the final episode.

Pertinent history revealed that the patient was the second youngest of ten children; but that only she and the youngest child, a sister, were at home with their mother and father during the developmental years. She stated that she had never confided in either her sister or her parents. At the age of 15 she bore an illegitimate baby boy who later proved to have cerebral palsy. At 16 she marmied a chronic alcoholic and shortly thereafter gave birth to a healthy girl. The following year she aborted at five months, and at that time the attending physician told her that it had been necessary for him to perform a procedure which would prevent her from having more children. She married her present husband, "a wonderful man", two years ago.

The patient remarked that she experienced sour eructations, nausea, and vomiting during each of her pregnancies. She revealed also that her sister-in-law, who was pregnant at the time of her last two episodes, manifested ankle, wrist, and periorbital edema. She recalled that during the third event the abdominal swelling and other symptoms disappeared on the day following the onset of her menstrual period. In describ-

ing herself, she declared that she had been "nervous" most of her life. When asked how she had felt during her pregnancies, she answered: "I wish I were pregnant now, if that's what you mean." Her husband volunteered that a week does not pass without his wife's expressing the wish that she were pregnant.

Discussion

Usually defined as a condition in which the symptoms and signs of true pregnancy are simulated in whole or part, pseudocyesis[1] or spurious pregnancy has been found among practically all races and classes of people. Most cases appear during the childbearing period, but there have been reports of occurrences during the prepuberal and postmenopausal periods. Chaste women, the married with or without children, and widows have experienced the condition. Some have had children following pseudocyesis. The classical case history usually involves a woman of neurotic tendency who, for some reason, has strong desire or intense fear of being pregnant. Bivin and Klinger[1] point out that spurious pregnancy has been rather frequent in occurrence at the beginning of second marriages, for after the woman remarries she may hope to be more fortunate in having a family. If she loves her present husband and he desires children, she may have a strong desire to become pregnant.

Pohl[2] believed that the patient must have a knowledge of the symptoms of pregnancy in order for the entity to develop. These symptoms may include abdominal enlargement, amenorrhea, breast changes, capricious appetite, weight gain, and gastrointestinal disturbances such as nausea and constipation. The changes found in the breasts, uterus, and vagina, however, are never exactly the same as found in true pregnancy but are only mild changes in that direction.[3] There is no enlargement of the uterus.[4] The condition may continue for nine months or longer, the patient feeling "fetal" movement and undergoing "labor" pains. The explanation of "fetal" movement probably lies in the movements of the intestines or in spasmodic muscular contractions of the abdominal wall, while "labor" pains have been associated with the voluntary lowering of the diaphragm. Excess fat in the omentum and gas in the intestines are believed to be the chief causes of the abdominal enlargement.[1]

It has been stated by Moulton[5] that the syndrome of pseudocyesis appears to be one of many grades and types, so that it cannot be regarded as a uniform entity with one explanation. One type is said to consist of a hysterical mimicking of the external signs of pregnancy, with few endocrine changes except amenorrhea. In fact, Kehrer[6] maintains that in many instances mental phenomena were present to a marked degree even in the absence of any bodily changes. The other type consists in further endocrine involvement. It is conceivable that the first type with the hysterical features and minimal symptoms is really an abortive type of one process. If allowed to continue, it would appear as full-blown pseudocyesis progressing to "term" with typical endocrine involvement and bodily changes. Whether or not the condition is one continuous process, it has been the belief of at least one author[7] that the entity is not purely a psychological disorder, in that most of the symptoms and signs are the result of true endocrine changes. It is generally accepted that stimulation of the hypothalamus is necessary for the pituitary gland to release hormones which act on the ovaries and begin the normal menstrual cycle. A number of investigators[8] have proposed that cortical impulses due to emotional factors cause hypothalamic inhibition, resulting in cessation of menstruation, breast changes, and the appearance of other signs of pregnancy.

We are upholding the widely accepted concept that the psyche is the causative factor of pseudocyesis. This is to be distinguished from organic pseudopregnancy which is caused primarily by hormones or hormone-like substances released into the bloodstream by tumor or hyperplasia, or administered as a medicament, resulting in symptoms and signs simulating true pregnancy. In some instances the appearance of symptoms or signs of pregnancy, such as amenorrhea, which may be due actually to organic disease, may precipitate a condition of pseudocyesis.[9] Even here, one may presume that the individual is predisposed to the condition, and that there is present a drive or motive for becoming pregnant.

Liepmann[10] infers that the unconscious phase of pseudocyesis begins after the appearance of amenorrhea, but we maintain that it may start before the onset of this sign, as was illustrated in our patient. By the

unconscious phase we mean simply that early period of the condition before the patient is aware that she is "pregnant." We must bear in mind that the patient is not conscious that she is "pregnant" until she is cognizant that her symptoms and signs are those representing pregnancy. In certain rare instances, and we are referring to Brill's[11] way of thinking, it is conceivable that a woman may foretell that she is "pregnant" prior to the onset of any symptoms or signs. Sensations resulting from metabolic changes related to the organs of reproduction arouse associations in the mind which were present at the time the patient was pregnant previously.

Our patient was seen on each of the four occasions during the unconscious phase of pseudocyesis. The condition did not progress beyond this phase, the patient having been unaware that she might be pregnant, even though minimal symptoms and signs were present. Not suspecting pregnancy, she did not relate the possibility of such a condition during the routine history-taking; and the attending physicians, likewise, did not entertain this in their differential diagnoses. One can see how the patient's nonspecific symptoms and signs were overlooked as being those of pregnancy. The abdominal enlargement and mild edema can be attributed to a gain in weight. Most of the other symptoms are those of any number of common gastrointestinal disorders. It was the psychiatric interview which revealed the patient's essential history, motivation, and dynamics, and led to the correct diagnosis.

Concerning the abortive aspects of pseudocyesis, we must recall that some women have most of the symptoms and signs of pregnancy and go on to "term," whereas others may have a few symptoms, or only one, which may be short-lived.[1] In the usual course of events the patient in the beginning presents minimal symptoms and signs, such as morning sickness and amenorrhea. The process, a dynamic one, continues with a concomitant increase in symptoms and physiological changes until the time of expected delivery. The completeness of the condition depends upon a variety of factors, one of the most important being the extent to which the idea of pregnancy takes possession of the patient's entire personality.[12] In order for the process to continue, it is essential that it be reinforced with stimulating impulses,[10] confirming the existence of the condition, as might be derived from the actual presence of the symptoms and signs of pregnancy or from a physician's mistaken diagnosis of pregnancy.[2] These stimulating impulses will cease to be of any consequence, resulting in an abortive process, if the patient gains sufficient insight indicating the impossibility of pregnancy. This insight may be realized through the patient's own reflections or from external sources, such as psychotherapeutic interpretations. In our patient, factors which were instrumental in causing interruption of the pseudocyetic processes include the incompatibility of pregnancy and sterility, and the onset of the menstrual flow during the third event. No recurrences have followed the fourth episode since its termination by the psychiatric interview one year ago.

During the last century there were many cases of pseudocyesis recorded in the literature, but there have been relatively few reports since that time. Authors[8, 13] differ as to whether or not the incidence has decreased; however, no valid statistics have been compiled. One reason offered for the infrequent recording of the disease is that there has been a lack of interest in the subject.[3] It is our opinion that we are seeing more of the abortive type of pseudocyesis today than was seen by our forebears, and that it is either not recognized or not given its proper consideration because it is assumed to be of a fleeting and innoxious nature.

Just as years ago many people did not seek medical aid until they were afflicted with enormous ovarian cysts and far-advanced malignant growths, so too, many pregnant women refused to be examined by a physician or a midwife until they were in labor. Today, with earlier visits to the obstetrician and with more accurate means of diagnosis at his disposal, such as roentgenography and the biologic tests of pregnancy, which are sources of insight for the patient, not as many women with full-blown pseudocyesis are being seen. We hypothesize that with the progress of medical science and the education of the general population, the condition will tend to abort at an earlier month than previously, so that in the not too distant future the symptoms and signs associated with the disease will be confined to those seen in the first trimester of pregnancy. Eventually, as was the case with our patient, insight will be derived and the condition will be arrested when it is still in the unconscious phase. In keeping with Laughlin's[13] specula-

tions regarding major hysterical conversions, we believe that as people become more cultured and sophisticated, their emotional conflicts will seek a more profound, sophisticated mode of expression than that of spurious pregnancy. We feel that the incidence of pseudocyesis is decreasing, and that in the future it will be looked upon as a "dying" entity.

Summary and Conclusions

A case of the abortive type of pseudocyesis is presented in which are manifested only nonspecific symptoms and signs of pregnancy. The unconscious phase of the condition is discussed and pointed out to be a diagnostic problem. From a consideration of the abortive aspects, we hypothesize that pseudocyesis in the future will prove to be a "dying" entity.

11 Traverse Street.

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Surgical Management of Occlusive Coronary Artery Disease

Presentation and Evaluation of Currently Applied Procedures

By RICHARD J. BOTHAM, M. D., WILLIAM P. YOUNG, M. D., and JOSEPH W. GALE, M. D.*
Madison

A REVIEW of the literature concerning the experimental and clinical procedures used in the surgical management of myocardial insufficiency leaves the overall impression that such procedures merit further investigation and consideration. The United States Public Health statistics[1] concerning this disease reveal that, in 1955, 405,830 persons in the United States died of arteriosclerotic heart disease. This figure exceeds by greater than 165,000 the number of deaths due to cancer in the same period and establishes arteriosclerotic heart disease as the most common cause of death in the United States.

Nearly everyone is aware of a number of patients who have lived many years with angina pectoris. However, in a series of 5,766 patients followed by Block and associates[2] for 5 to 23 years, the average span of life in patients with angina pectoris, without the consideration of the presence or absence of infarction, was approximately five years. The mortality rate in acute coronary occlusion has varied between 15% and 25%. Figures concerning longevity after the first attack of coronary occlusion are still more revealing. In Sigler's[3] series of 1,208 cases only 45.3% of males and 39.8% of females were alive at the end of five years. Katz and associates[4] reported that 75% of a series of 488 cases with infarction were dead at the end of three years. Many other statistical studies only serve to corroborate the impression that the prognosis associated with occlusive coronary artery disease is not good.

The scope of this presentation does not permit a detailed discussion of the working capabilities of patients surviving infarction. It is, however, a well-established fact that curtailment of many normal activities is an integral part of the management of many such patients. There exist very few patients who are not cognizant of the significance of the discomfort commonly called "angina pectoris" which in its more severe form may be totally incapacitating. Suffice to say, that any therapeutic approach to occlusive coronary artery disease which will improve the associated prognosis or which will diminish the frequency and/or severity of associated angina, and enable such patients to enjoy a more normal or more comfortable existence, merits consideration.

A barrier to the acceptance and clinical application of the variously proposed procedures has been the inconsistency of results reported by various investigators relative to the same type of procedure used on experimental animals. In addition there has been considerable criticism of test procedures because they have been used on normal animal hearts rather than on hearts which have varying degrees of occlusive disease. The production of occlusive disease states in the experimental animal to simulate human heart disease, in an attempt to more accurately evaluate subsequently applied test procedures, is extremely difficult if not impossible to attain. Most test procedures have been evaluated by a comparison of mortality and magnitude of infarction following coronary artery ligation in control and test animals.

A historical review of the surgical management of occlusive coronary artery disease will not be presented. However, the fundamental methods which have been used are encompassed in the following categories:

(1) Nerve interruption.
(2) Reduction of basal metabolism by the production of myxedema.
(3) Development of collateral circulation by vascular grafts.
(4) Development of collateral circulation by the production of cardiopericardial adhesions.

* From the Department of Surgery, University Hospitals, Madison 6, Wisconsin.

(5) Development of existing anastomotic channels.
(6) Local resection of pathologic lesions.

The purpose of this paper is to present and evaluate the current surgical management of occlusive coronary disease and encompasses experimental and clinical work performed by Thompson, Beck, Vineberg, Glover, and Battezzati.

Four current procedures exist which have been tested experimentally and have had sufficient clinical application to be of statistical significance. The first of these is the cardiopericardiopexy procedure which Thompson[5] has investigated since 1942. Secondly, since 1946, Vineberg's[6] work with internal mammary artery implantation has also yielded interesting results. Claud Beck's[7] extensive investigations in this field since 1935 have produced a procedure which he feels worthy of clinical application. Lastly, the recent use of bilateral internal mammary artery ligation which was first proposed in 1939 by Fieschi merits some discussion.[8] Many other procedures have been and are being investigated but the scope of this presentation does not permit their inclusion.

Thompson's Procedure

Cardiopericardiopexy was first reported by Thompson[5] in 1942 and has often been referred to as the "talcum powder heart operation." The operation consists of removing a portion of the left fifth costal cartilage to gain access to the pericardium without entering the left pleural space.[9] The pericardium is then opened and the pericardial fluid aspirated as completely as possible. The surface of the heart is then completely covered with from 4 to 6 gm. of magnesium silicate. Thompson feels that the silicate powder is an extremely strong irritant and therefore he omits scarification or removal of any of the epicardium. Introduction of the silicate powder results in an acute inflammatory reaction with hyperemia of the myocardium as well as the production of a granulomatous pericarditis with associated extracardiac and intracardiac vascular anastomoses which have been demonstrated to persist as long as ten years.[10] Thompson reasoned, and subsequently demonstrated, that since the particles of magnesium silicate powder are not absorbed and very little is removed via the lymphatics or by phagocytes, the greater part of the powder remains fixed in the adherent tissues of the pericardium and myocardium. The silicate powder serves, then, as a constant source of irritation, hyperemia, and stimulation in the formation of new intra- and extracardiac blood vessels. The criticism of cardiopericardiopexy has been that the ensuing reaction may be comparable to or eventuate in actual constrictive pericarditis. Thompson feels that such a comparison is erroneous and states that although the pericardium is adherent it has never been known to constrict or impede the myocardium in any degree. Necropsy studies of patients up to ten years[10] after cardiopericardiopexy have displayed no evidence of constrictive pericarditis.

During the past few years Thompson has rigidly limited the indications for operation to those cases with marked degrees of disability. In a series of 250 patients he[11] reports only 10% poor results and 90% of the patients are improved more than 50%. Approximately 40% of the patients are more or less normal and are considered excellent results. Almost all patients had infarction prior to operation and the vast majority were nearly completely incapacitated. The operative and hospital mortality in this series of 250 patients was 7%.

Vineberg's Procedure

Vineberg[12] first experimented with internal mammary artery implantation in 1945. The procedure which he has devised consists essentially of freeing the left internal mammary artery from the chest wall, from the fourth to the sixth intercostal space.[13] The distal end is doubly ligated and divided between the ligatures. A tunnel is made in the anterior wall of the left ventricle and the freed portion of the artery is pulled into the tunnel and fixed distally. The intercostal vessels which arise from the freed portion of the internal mammary artery are ligated except for the sixth intercostal which is transected just before implantation of the artery in the myocardial tunnel. The internal mammary is thus placed within a tunnel in the ventricular myocardium with an open, freely bleeding sixth intercostal branch. In the experimental animal, the implanted internal mammary has been shown to send out large branches in the ventricular myocardium in 71% of cases.[14] These branches have been demonstrated to carry a supply of fresh blood into the heart at a rate as high as 51 cc. per minute.[12] Peri-

cardial fat pads are applied to the surface of the left ventricle to supplement the internal mammary revascularization of the ventricle.

Since the first clinical case in 1950, Doctor Vineberg[15] has performed internal mammary artery implantation in 57 patients. Seventeen of these patients were bed-chair invalids who suffered pain at rest without exciting cause and were considered to have angina decubitus. Forty patients had no pain at rest without an exciting cause, although many had pain initiated by minimal exertion or emotional excitement. The operative mortality in the angina decubitus patients was 59% while in the group without angina at rest it was 5%. A follow-up reveals that in the angina decubitus group only 2 (12%) of the original group may be considered to have improved following internal mammary artery implantation. In the group of 40 patients with no angina at rest 78% were unable to work prior to operation and 88% of the survivors have returned to work. In a survey made six months to seven years after operation 75% of the entire series of 57 patients are alive and 60% are working full time.

Beck's Procedure

Probably the best known operative procedure for coronary artery disease is that devised by Beck[7] based on some 5,000 experimental operations carried out on dogs. Beck's current procedure consists of essentially four steps, namely:

(1) Narrowing of the coronary sinus, which is accomplished by tying a ligature about the sinus and over a probe approximately 3 mm. in diameter and then removing the probe.
(2) Abrasion of the lining of the pericardium and epicardial surface of the heart to produce inflammation and resultant intercoronary channels.
(3) Application of about 0.3 gm. of coarsely ground asbestos to the surface of the heart to produce a mild inflammatory reaction.
(4) The bringing of the mediastinal fat in contact with the heart so that it can act as a graft upon the heart.

The effectiveness of Beck's operation is evidenced by the fact that the mortality associated with one-step ligation of the descending ramus of the left coronary artery at its origin, was reduced from 70% in control dogs to 26.6% in the test dogs. The magnitude of infarction was also reduced by 60% to 70% by this operation. Furthermore, it was found that the average backflow from the transected distal circumflex coronary artery in test dogs was 8.5 cc. per minute compared to a backflow of 3.8 cc. in normal control animals or an increase of 4.6 cc. per minute.

Beck has applied his operation clinically to 285 patients[16] with an overall operative mortality of 6.3% and an operative mortality during the past two years of less than 4%. He feels that the operation is best performed as an elective procedure applied as early as possible in the clinical course of coronary artery disease. Beck has classified his operated patients into three groups.[17] The first group has mild symptoms, is usually less than 50 years of age, and may have a small infarct and/or mild angina. The second group has moderately advanced disease, moderate to severe angina, one or more infarcts, and a heart of normal size. The third group includes those with extensive muscle damage who may have a large heart and are considered salvage cases. Beck has avoided surgery in patients with acute infarction or impending acute infarction, younger patients with rapidly progressive symptoms, those with cardiac enlargement and evidence of congestive failure, and patients with severe hypertension or any other disease which per se contraindicates operation. Seventy-five per cent of a group of 225 operated patients have had at least one clinically proved myocardial infarction.[18] Brofman[18] reports that, of 100 consecutive patients operated upon by Beck without a mortality, 90% displayed excellent symptomatic results and 90% were economically productive. Only 45% of these patients had been able to work one-half time or more prior to surgery. The expected mortality in a group of 137 consecutive cases followed for five years postoperatively was 30%, while in reality it was only 13.1%.

Battezzati's Procedure

In 1939 the first bilateral internal mammary artery ligation for myocardial insufficiency was performed in Italy. This work was not amplified until 1955 when Battezzati and others[5] reported their experience with 11 patients in each of whom the anginal syndrome was abolished following bilateral internal mammary artery ligation, and remained so even after the patients had re-

turned to normal activity. In addition, the preoperative electrocardiographic recordings were modified favorably in 8 of the 11 patients.

It has long been known that there were communications between the parietal pericardial vessels and those of the myocardium occurring primarily about the bases of the pulmonary artery and the aorta.[19] The pericardiophrenic artery, the major blood source to the pericardium, arises from the proximal portion of the internal mammary and ligation of the internal mammary is performed distal to the origin of the pericardiophrenic artery. Transformation of the high "end pressure" in the parent artery, just proximal to the point of the ligation, into "lateral pressure" in the branches of the pericardiophrenic artery supposedly results in an increased flow through these branches to anastomotic channels of lesser pressure. This is the proposed rationale for the procedure.[20] Recent studies in our laboratories[21] have revealed that while there is a definite increase in pressure associated with ligation of the internal mammary arteries there is an associated simultaneous increase in systemic peripheral arterial pressures including intracoronary arterial pressures. Our clinical experience with the procedure as yet is not sufficient to allow a proper evaluation of its efficacy.

Little experimental evidence exists to date to corroborate the clinical results obtained by the Italians and others who have applied the procedure in this country. The clinical results are worthy of note, however. Battezzati[22] recently reported a series of 300 cases in which 30% to 50% of patients had complete relief of symptoms. Thirty per cent had definite marked improvement and 20% had no improvement at all. Lazaro[23] reported that approximately 200 bilateral internal mammary artery ligations had been performed at Georgetown University for occlusive coronary disease with approximately 70% resulting in complete or marked relief of symptoms. Glover[20] reported experience with 135 such cases and has noted definite improvement in 65% to 70% of his cases.

Postoperative Improvement

We have presented four procedures which are being clinically applied in the surgical management of myocardial insufficiency and the reported results associated with their use. We must now consider the experimental and clinical objective evidence available to date to corroborate the reported subjective postoperative improvement.

Experimentally, the only common point of evaluation is the diminished mortality following ligation of the anterior descending coronary artery. Each investigator reports some insurance against myocardial infarction following his respective procedure in canine subjects. It is questionable and difficult to determine whether this information obtained in dogs is applicable to human subjects whose intercoronary system differs significantly from dogs. Furthermore, there exists no way of accurately measuring whether or not there is an increased coronary flow associated with any of the discussed procedures. Electrocardiography and ballistocardiography are of little help in the objective evaluation of the experimental procedures applied to normal dogs or those treated following partial segmental occlusion which may be produced by wrapping the coronary artery with cellophane.

Clinically there also exists no way of accurately measuring whether or not there is an increased coronary blood flow associated with the discussed procedures. Electrocardiographic and/or ballistocardiographic improvement was reported, however, in 46% of Glover's patients[20] having undergone bilateral internal mammary artery ligation. Definite electrocardiographic improvement has also been reported following the internal mammary implant procedure advocated by Vineberg.

Lastly, and of paramount importance, is the problem of evaluation of the psychological effects of suspected occlusive coronary disease and subsequent surgical therapy. One cannot underestimate the tremendous psychological impact of sudden awareness of suspected or proven myocardial ischemia. In the light of a paucity of objective investigative and clinical findings to substantiate the reported marked subjective improvement following revascularization procedures, it is extremely difficult not to ascribe some, if not a major amount, of the subjective clinical improvement to psychological factors. It is obvious that there exists a need for further investigation of the problem of myocardial revascularization before the currently applied procedures can be endorsed for extensive application in the surgical treatment of occlusive coronary artery disease.

Summary

The rationale and description of the four major procedures currently applied to the surgical management of occlusive coronary disease together with the clinical results associated with their use has been presented.

It is apparent that there exists today few measureable objective criteria by which the physician can critically evaluate the surgery of coronary artery disease. The clinical results reported by various investigators, however, reveal that, in spite of a lack of critical objective evidence of the true value of the applied procedures, the subjective improvement experienced by patients following such surgery makes the procedures worthy of consideration. It is hoped that further experimental and clinical experience with the previously discussed procedures will reveal their true place in the therapeutic armamentarium of occlusive coronary artery disease.

1300 University Avenue.

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BOOKLET ON IMMUNIZATION FOR INTERNATIONAL TRAVEL

A new edition of the booklet "Immunization Information for International Travel" was issued this week by the Public Health Service, Department of Health, Education, and Welfare.

The booklet is designed primarily for use of travelers going abroad and for health departments and physicians. It gives current details on immunization requirements for persons entering the United States, including Americans returning from abroad. It also lists requirements and recommendations for immunization in 200 other countries, and in some cases, additional recommendations of the Public Health Service for American travelers.

Information on bringing pets into the United States from other countries is included in a special section.

Prepared by the Division of Foreign Quarantine of the Public Health Service, the booklet is for sale by the Superintendent of Documents, Government Printing Office, Washington 25, D. C., for 30 cents.

THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

The twenty-second annual meeting of The New Orleans Graduate Medical Assembly will be held March 2, 3, 4 and 5, 1959, with headquarters at the Roosevelt Hotel.

Eighteen outstanding guest speakers will participate and their presentations will be of interest to both specialists and general practitioners. The program will include 54 informative discussions on many topics of current medical interest, in addition to clinicopathologic conferences, symposia, medical motion pictures, round-table luncheons and technical exhibits.

Following the meeting in New Orleans, arrangements have been made for a clinical tour to Mexico City, Cuernavaca, Taxco, Acapulco and San Jose Purua, leaving from New Orleans on Friday, March 6, and returning on Saturday, March 21.

Details of the New Orleans meeting and the clinical tour are available at the office of the Assembly, Room 103, 1430 Tulane Avenue, New Orleans 12, Louisiana.

PREPARATION OF MANUSCRIPTS FOR THE WISCONSIN MEDICAL JOURNAL

Exclusive Publication: Articles are accepted for publication on condition that they are contributed solely to this Journal. Publication elsewhere will be subsequently authorized in the discretion of the Medical Editor.

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Identification: Place the name of author and page number at the upper left-hand corner of each page except the first.

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4. Doe, J. E.: What I know about it,
Wis. Med. J. 54:717–719 (Dec.) 1954.

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Under ordinary circumstances articles are scheduled about six months in advance. The approximate date of publication, subject to change, will be given the contributor when the article has been accepted.

Society members throughout the state are encouraged to write up their interesting cases and submit them for publication. The editorial staff welcomes the opportunity of helping you prepare your article for the printer.

Glaucoma*

Its Great Importance to Every Physician

By LAWRENCE L. GARNER, M. D., and F. HERBERT HAESSLER, M. D.

Milwaukee

AN UNDERSTANDING of glaucoma is of utmost importance because: (1) it affects unbelievably many people and leads to blindness if neglected, (2) it is easily recognized, and (3) with adequate care usable vision can usually be retained throughout life. It is startling to note that it is estimated that 2% of all people in the United States over 40 years of age have glaucoma and a great many are unaware of it. If they live long enough and if they are not treated for glaucoma, they will be blind. Of the totally blind, 15% are blind from glaucoma. Statistics show that glaucoma occurs 20 times as frequently as tuberculosis and 5 times as often as cancer.

The one essential manifestation of glaucoma is increased ocular tension which is the result of increased intraocular pressure. The tension may be increased without causing pain or any other manifestation which might attract the patient's attention. It does reduce vision in time but this is very gradual and begins in the periphery; the patient is often completely unaware of the loss until so little is left that it is hardly useful. Moreover, if treatment is begun in this late stage the eye continues to degenerate nonetheless. However if the disease is recognized early, treatment is usually entirely effective and the patient can retain vision for the remainder of his life.

The recognition of increased tension is of such enormous importance that it is the conservative opinion of ophthalmologists that everyone over 40 years of age should have his tension measured. In a number of medical schools, of which our school is one, the senior students are taught that the measurement of tension is an essential part of every physical examination and in these schools the students are required to measure the tension in every patient assigned to them on the medical wards of their teaching hospital. The measurement of tension should also be required of all interns.

How Is Tension Measured?

Tension is measured with a tonometer. The procedure is not time consuming and it is indispensable in the diagnosis of glaucoma. A tonometer is a device with which one can lay a weight on the eyeball and measure how deeply the cornea becomes indented. It consists of a tube, the lower end of which is a concave foot plate. The foot plate is so curved that it fits the curvature of the eyeball. A cylindrical weight within the tube depresses the wall of the eyeball in inverse proportion to the hardness of the globe. A pointer and a scale provide a means of measuring the depth of the depression.

When measuring tension, the eye is anesthetized with a local anesthetic; a 1% solution of tetracaine hydrochloride (pontocaine) is satisfactory. The instrument which has been sterilized (and if sterilized chemically the solution must be thoroughly removed by rinsing and the tonometer meticulously dried) is placed on the eyeball. One takes great care to hold the tonometer vertical and to place the foot plate on the cornea gently and well centered. If the tonometer is properly placed the edge of the foot plate is in a position in which it will not injure the cornea.

Importance of Glaucoma

Glaucoma is interesting to every physician from two points of view: (1) the technical, and (2) the social.

The Technical Aspects: The technical data are outlined in a subsequent segment of this essay. It is not only the ophthalmologist to whom they are important. Every physician, be he general practitioner, internist, surgeon, obstetrician, or active in one of the other specialties has a number of patients each one of whom thinks of him as "my doctor." He is "my doctor" because the patient intuitively discovered that this doctor understands him

* From the Eye Clinic of Marquette University School of Medicine.

and can sympathetically help him comprehend his problems. It is for these patients that every physician must, among many other things, understand glaucoma.

The Social Aspect: Since an increase in tension is the essential characteristic of glaucoma and the characteristic by which glaucoma is recognized, it is obvious that the pressing social problem is to induce everyone over 40 years of age to have his tension measured. It is not enough to merely publish an explanation of the importance of tension. Many people who understand this and understand the importance of knowing the tension will postpone having it measured. Are not most of us procrastinators even in things of utmost importance to us? By the way, how long is it since *you* have had your tension measured? Have you ever had it measured?

In the social problem the universal measurement of tension is paramount and the ophthalmologist is so insistent because he is enormously impressed by the calamity of blindness. Like most physicians, the ophthalmologist is an individualist who is most deeply impressed by his responsibility to the individual human being under his care. He has seen the hardship and terror associated with impending blindness and is eager to save from it every individual whom he can reach. His urge is to have every member of the community come for measurement of tension for the sake of his own vision and for him it is "social" only because he wants to reach every member of the community in time.

But how is this to be achieved? How is he to impress everyone with the importance of timely diagnosis? If people cannot be persuaded to come on their own initiative one of the measures one can resort to is screening. Screening is one of the watchwords of social medicine, but it does not necessarily have to be wholesale diagnosis. It can be used as a method to bring the potential patient to the doctor even though his initiative is inadequate; what is done during screening can be as individual a treatment of each patient as is possible under any other circumstances. Screening is essentially a sifting of those who need further study from those who obviously are justified in giving their eyes no further thought for a year or two. It is generally accepted as a conservative procedure. However there are those who point out that subjecting anyone to such community action as screening is undermining his freedom and sense of responsibility; but they lay themselves open to the criticism that they are hopelessly behind the times, archconservatives or medieval relics left behind by the stream of community cooperation.

Clearly, screening accomplishes something for which other means of persuasion seem inadequate. It brings people to submit to a harmless diagnostic procedure which is of inestimable value to them. A large group, often of a thousand or more, is brought in because of the decision of an enthusiast or, if you will, a zealot or fanatic. However, everything is accomplished at a cost and there are at least two components in the price that is paid by those who do not come on their own initiative. One is the loss of the will to maintain freedom of choice. The other is the danger of worry which nags some people for a long time once the train of thought is suggested to them. Such people can be made miserable if the ophthalmologists offer to screen for glaucoma and other well-meaning groups suggest a similar course for high blood pressure, cancer of the lung or colon, gastric ulcer, and perhaps many equally justifiable ventures which do not occur to an ophthalmologist.

As we gain experience, the best and easiest course for recognizing glaucoma in large numbers of people will emerge. The decision will depend on many factors and the plan finally adopted will doubtlessly emerge as the result of decisions made by patient and physician alike.

We should also like to point out that screening is not the only possible solution to this problem. If all physicians will make the measurement of ocular tension an integral part of every physical examination of every patient, the need for screening would be enormously reduced. And when we say "all physicians" we are speaking to the ophthalmologists as earnestly as to all others. The ophthalmologists too are not sufficiently aware of the great importance of measuring the ocular tension of every patient over 40 years of age. At the last meeting of the American Medical Association the National Society for the Prevention of Blindness had a booth in which they measured the tension in everyone whom they could persuade to come in. Of the 540 physicians who accepted the invitation 22 had a tension of 26, high enough to make it important to study the eyes thor-

oughly. Five of the 22 subjects volunteered that they were under the care of an ophthalmologist at the time and that he had not measured the tension. Is it clear that we are talking to the ophthalmologist as well as to all other physicians?

Whatever one's own attitude toward screening or that of the community may be, the fact remains that the danger of glaucoma is inadequately recognized by layman and physician alike. We must exploit every means at our command to make it clear that people of middle age must be made aware of a very real danger to their eyes.

Nature of Glaucoma

Common to all types of glaucoma is an elevated ocular tension, but that is not its only manifestation. There are several other signs and symptoms and most of them are the result of the increased tension. The most distressing of these are pain, which may be excruciating, and loss of vision. The loss of vision is the result of atrophy of the optic nerve which occurs because the intraocular pressure is greater than the blood pressure in the small arterioles upon which the optic nerve depends for oxygenation and nourishment. As a result of the increased intraocular pressure the atrophic tissue of the optic nerve recedes and gives rise to an ophthalmoscopically recognizable depression of the proximal end of the nerve which is the optic disk in the ophthalmoscopic picture.

In all glaucoma there is an imbalance between the rate of secretion and of drainage of the fluids in the eyeball which are of great importance in the normal metabolism of the ocular tissues of the eye. These fluids are secreted by the ciliary body, find their way through the pupil into the anterior chamber, and leave the eyeball by way of channels of drainage in the corneoscleral tissue in the region of the limbus. Most glaucoma occurs because there is interference with drainage. If the inadequacy of drainage is the result of a primary defect in the tissues, the glaucoma is called primary. In primary glaucoma, drainage may be inadequate because the arrangement of tissue in the angle of the anterior chamber is such that the aqueous does not have access to the trabecular tissue which is its normal exit. In some eyes drainage may be barely adequate most of the time but completely closed when the pupil becomes dilated and the iris tissue is crowded into the chamber angle. In other eyes with primary glaucoma the chamber angle may be wide open under all circumstances, giving the aqueous free access to the trabecular tissue, but drainage may still be impaired because the trabecular tissue itself may be abnormally dense. In many instances the glaucoma is the result of a hemodynamic disturbance, many of the details of which are only surmised or completely unknown.

Diagnosis of Glaucoma

The most important step in the management of glaucoma in any patient is the recognition of its existence. Once the disease has been recognized the ophthalmologist meticulously explores the fundus ophthalmoscopically for damage to the optic nerve and the visual field for earliest and often minimal loss of function. Complete, meticulous study of the field may be very time consuming but it is essential. Inspection of the chamber angle by gonioscopy and continuous recording of changes of tension by tonography are further refinements which are not as widely used. It is these data which reveal the nature of the disturbances of function and structure in the glaucomatous eye and provide the basis for planning the program of therapy.

Treatment of Glaucoma

The two forms of therapy most widely used are: (1) the instillation of solutions of miotic drugs, and (2) surgical procedures. The action of the miotic drug is obvious in those cases in which an attack of glaucoma has been precipitated by mydriasis. In such an eye the iris has been pressed into the chamber angle and has closed the channels through which the aqueous leaves the eye; contraction of the pupil as a result of the instillation of a miotic drug pulls the iris tissue out of the chamber angle and restores free passage to the channels of drainage. Its effect is less clearly understood in most cases of chronic simple glaucoma in which it nonetheless reduces the tension to normal and often continues to do so for years. There are also other effective drugs, for example acetazoleamide (diamox), an inhibitor of carbonic anhydrase, which, instead of promoting drainage, reduces the rate of secretion of aqueous.

When drugs fail to reduce the tension and the ocular functions are progressively deteriorating, surgery becomes necessary. Many operations have been devised which differ from one another in detail, but fundamen-

tally surgery is done either to provide new channels of drainage of the aqueous in a subconjunctival or subchoroidal field or to reduce the secretion of fluid by producing partial atrophy of the ciliary body where the fluids arise. Which of the many therapeutic measures is chosen in any individual patient depends on a thorough study of many factors —the type of glaucoma, its stage of development, the variations and magnitude of tension, the changes of visual acuity and visual field during the course of observation, the details of gonioscopy and tonography, the response to previous therapy, and the mental attitude of the patient.

Summary

1. Glaucoma is a common disease which leads to blindness if untreated; 2% of people over 40 years of age have ocular tension greater than normal and 15% of the totally blind in the United States are blind from glaucoma.

2. Glaucoma can be recognized by measuring the ocular tension; this simple measurement can be made in a few minutes.

3. We emphasize our hope that this article will convince its readers that the detection of glaucoma is so enormously important that the measurement of tension will be made a part of every physical examination of patients over 40 years of age.

561 North Fifteenth Street.

FILM—"CHEMOPALLIDECTOMY IN THE TREATMENT OF HYPERKINETIC DISORDERS"

The Sister Elizabeth Kenny Foundation has produced a film dealing with the surgical procedures of Dr. Irving S. Cooper to relieve Parkinsonism and other involuntary movement disorders. Dr. Cooper's research is being carried on at New York University–Bellevue Medical Center and St. Barnabas Hospital in New York City with the support of a Kenny grant.

To date, Doctor Cooper has performed his operation on more than 850 patients. His work was portrayed at a symposium at Bellevue Medical Center in May with some 500 neurologists and neurosurgeons from all parts of this country, as well as a number of nations abroad, in attendance.

The surgical procedure of chemopallidectomy and chemothalamectomy is aimed at two tiny islands of overactive nerve cells in the Globus Pallidus and the Thalamus. Either or both centers are destroyed by injections of absolute alcohol to relieve tremor or rigidity.

The Foundation film, "Chemopallidectomy in the Treatment of Hyperkinetic Disorders," is approved by the American College of Surgeons. The film, which deals with an area in which there is mounting interest, is a 16 mm, color presentation, with sound, and it runs 24 minutes.

Anyone wishing to order the film may do so by writing to: Educational Film Division, Sister Elizabeth Kenny Foundation, 2400 Foshay Tower, Minneapolis 2, Minnesota, and specify first, second and third choice of dates for showing of the film.

NORTH SHORE HOSPITAL LECTURE SERIES DECEMBER 3 AT WINNETKA

The third lecture in the Ninth Annual North Shore Hospital Lecture Series on "Emotional Forces in the Family" will be held at the hospital, 225 Sheridan Road, in Winnetka, Illinois, on Wednesday, December 3, at 8:00 p.m. "The Role of the Father in the Family" will be discussed by Claire M. Ness, M.D., director, Cleveland Guidance Center, member of the board of directors of the American Orthopsychiatric Association, member of the board of directors of the Cleveland Welfare Federation, and consultant for Children's Services, Cleveland.

The Commission on Education of the American Academy of General Practice has approved these lectures for Category II credit. Doctor Ness has agreed to answer questions after her presentation. All physicians and allied professional personnel are invited to attend.

Clinicopathologic Conference

Sponsored by the Section on Pathology, State Medical Society of Wisconsin
Guest Editor: Norbert Enzer, M. D.

PRESENTATION OF CASE *

DR. CARL J. CHELIUS: A 55-year-old white man, a cattle dealer, complained on February 2, 1956, of cough, weight loss of 10 pounds, and slight dyspnea. These symptoms began 6 months prior in a rather mild, but progressive fashion. The cough was non-productive and there was no fever. Herpes zoster appeared with the onset of these symptoms, involving the right side of the chest wall, and disappeared within 4 or 5 days without residuals, except for slight pigmentation of the skin. Later, the cough was associated with a small amount of daily sputum. The first examination on February 2, 1956, disclosed a normal blood pressure and temperature, chronic conjunctivitis, an old perforated nasal septum, roughening of the mitral and aortic first sounds, and some pigmentation of the skin in the area of the herpes. The skin elsewhere appeared tanned and wind burned. The remainder of the physical examination did not at that time uncover any abnormalities. When submitted for laboratory tests, an anemia was discovered with a hemoglobin value of 11.5 gm.; red blood cell count, 3,600,000; white blood cell count 6,000; and sedimentation rate of 60 mm. in 1 hour. The blood smear was within normal limits. X-ray examination of the chest revealed a pattern which was diagnosed as indicative of some form of diffuse pulmonary fibrosis. The electrocardiogram was within normal limits except for low voltage and lowering of the T-waves in V5 and V6.

Two months later, gastrointestinal x-ray disclosed a nonfunctioning gallbladder, no abnormalities in the gastrointestinal tract, and again a bilateral interstitial pulmonary fibrosis. There was no evidence of bronchiectasis. The intravenous pyelograms were normal. Other laboratory tests to uncover evidence of syphilis, tuberculosis, numerous bacterial infections, and fungi were by bacteriological and sero-immunological methods all negative.

Again, 2 months later he was examined. This was 4 months after the original examination, and at this time the tan color of the skin was more brown. There was slight clubbing of the finger tips, the liver edge was palpable, and the sedimentation rate was rapid. The total proteins of the blood were 6.4 gm./100 ml. with slight increase in the globulins. Bone marrow pattern was within normal limits, the urine was normal, the serum bilirubin was 0.27 mg./100 ml., and the indirect serum bilirubin was 2.01 mg./100 ml. Again, the x-ray findings of the lungs were as previously noted. Erythrocyte fragility was not increased.

The patient continued with his work with few complaints until December 1956, 11 months after the original examination, when he was studied at another institution. In addition to the findings already described above, there were noted positive thymol turbidity and cephalin cholesterol flocculation tests, persistence of the anemia, the hyperglobulinemia, and the rapid sedimentation rate. Many of the previous laboratory tests were repeated, all with the same findings. At this time pulmonary function tests were performed and reported as "consistent with pulmonary fibrosis." A lymph node was removed from the right supraclavicular area, and this was found to contain evidences of chronic inflammation only. Bronchoscopic examination was negative and the bronchial smears negative for tumor cells. A needle biopsy of the liver was performed and this was reported as "hemochromatosis with pigmentary cirrhosis."

One month later, the patient developed edema of the ankles and swelling of the abdomen, and in February, 1957, the patient was admitted to Mount Sinai Hospital with jaundice, ascites, peripheral edema, and a nonprotein nitrogen rising from an initial value of 31.7 mg./100 ml. to pre-exitus value of 90.1 mg./100 ml. The serum bilirubin was 5.7 mg./100 ml., thymol turbidity was 3.1 cc., and cephalin cholesterol flocculation test was 4 plus. The prothrombin time now was 53%, apparently this being done for the first time.

* Department of Pathology, Mount Sinai Hospital, Milwaukee.

Figure 1

The urine contained 4 plus albumin and there was again about the same degree of anemia. The patient was lethargic and during the last week of his illness a pericardial friction rub was noted. The accumulation of fluid in the peritoneal cavity was rapid and paracentesis was necessary for respiratory relief. Coma and more severe edema developed and the patient died 13 days after this final admission to the hospital.

Dr. Morris Moel: The x-ray studies of the lung are significant—all other examinations were negative. The lung series (fig. 1) show a diffuse fine linear and granular and minutely nodular infiltration, slightly more manifest in the lower lung fields. The hilum areas are not involved, nor is there any abnormality of the cardiac silhouette. From a radiologist's point of view this series of films is indicative only of a persistent process not accounted for by edema or congestion. Many conditions were entertained such as sarcoidosis and metastatic malignancy; but we finally returned to our first opinion, namely a pulmonary fibrosis or interstitial pneumonitis of undetermined etiology.

Dr. Raymond Rice: The final diagnosis in this case was hepatorenal failure, hemochromatosis of the liver, and pulmonary fibrosis. This case presented several situations which seemed to us difficult to explain. The onset of his illness was the cough, dyspnea, and weight loss. The x-ray pattern of a diffuse interstitial pulmonary fibrosis focused attention on the lungs as the primary source of his trouble. At this time the liver was not enlarged. The lung pattern made it necessary for us to consider viral pneumonitis, sarcoidosis, interstitial pulmonary fibrosis of the Hamman–Rich type; and because this man's occupation was that of a cattle dealer, various types of mycotic infection and so-called farmer's lung and silo-filler disease seemed important. The onset, which was associated with herpes suggested a virus mechanism, but the continuity of this man's illness and the subsequent appearance of distinct liver pathology weighed against this etiology. Careful examination failed to uncover any evidence of sarcoid disease. The absence of skin lesions, lymph node disorder, bone pathology, and the normal bone marrow findings failed to support a diagnosis of sarcoid or malignancy. Because of the lung pattern by x-ray, a lymphangitic spread of carcinoma was considered, but all attempts to uncover a primary lesion failed. In connection with more specific conditions of the lungs such as mycotic infection and farmer's disease, we were unable to obtain any evidence to support such a diagnosis. The abnormal blood protein pattern suggested a myeloma, but this was ruled out by specific tests. The pathology of the liver established at least one disorder, namely hemochromatosis with cirrhosis, and certainly the terminal picture of ascites, edema, increasing jaundice, strongly positive laboratory tests gave ample evidence of rapidly progressing liver disease. Since the histology of the liver established at least one firm diagnostic evidence, the dominant role of the liver in this picture seemed to be clear. There remained, however, to account for the nature of the pulmonary fibrosis and up to the time of his death this was not solved. The terminal picture was that of uremia and no doubt the pericardial friction rub was on the basis of a uremic pericarditis. The final illness was characterized by evidences of irreversible liver and renal damage.

On the basis of this clinical story, we have nothing further to add to the diagnosis except to cling to the diagnosis of hemochromatosis of the liver with cirrhosis, complicated by terminal hepatic and renal failure, and an unaccountable pulmonary fibrosis which we

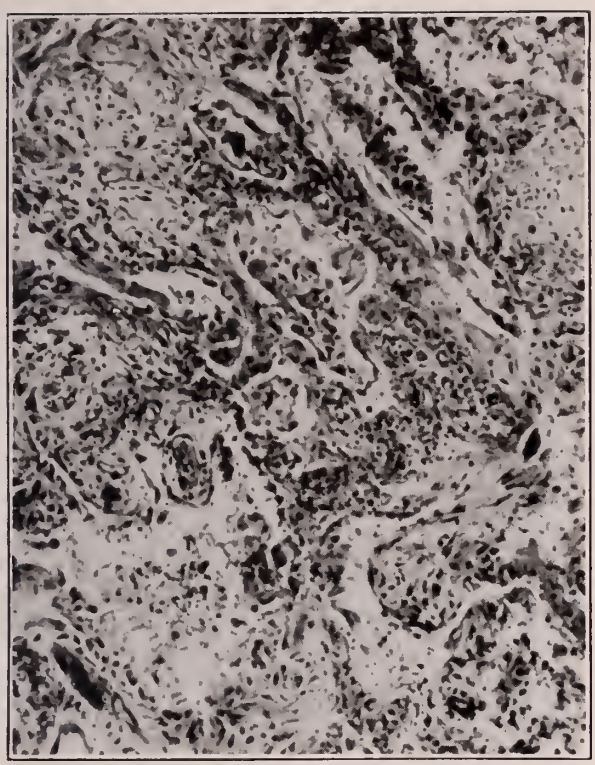

Figure 2

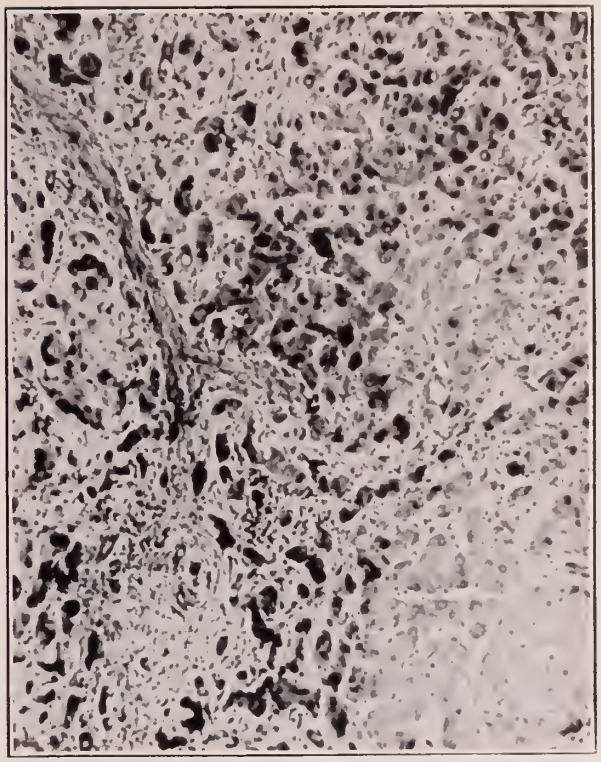

Figure 3

find difficult to equate or relate to the liver disorder.

Post Mortem Findings

Dr. Norbert Enzer: The post mortem findings may be summarized as follows: (1) Icterus. (2) Ascites and soft tissue edema. (3) Pericardial effusion. Absence of primary or intrinsic cardiovascular disease. (4) Bilateral massive pulmonary edema with congestion and icteric discoloration. In addition to these findings, the lungs presented irregular zones of gray consolidation, scattered mainly throughout the upper lobes. These areas of consolidation were smooth but other areas of the lungs had a finely granular quality. The pleural surfaces were not involved. (5) The liver was greatly reduced in size and weighed slightly less than 1,000 gm. It had a yellow-orange color and the parenchyma was permeated by a fine gray streaking which on cut surface gave the liver a fine nodular pattern. (6) The spleen was moderately enlarged and the surfaces dark red. (7) No abnormalities were noted in the pancreas or gastrointestinal tract. (8) The kidneys were swollen, cloudy, and slightly yellow.

The microscopic examinations of significance were those of the lungs and the liver. The lungs were characterized by a diffuse edema; thickening of the alveolar septa, many of which were lined by a homogeneous pink material; marked desquamation of alveolar cells; and scattered zones of young fibroblasts, lymphocytes, and macrophages in the alveolar septa. In addition many foci of organizing and healed pneumonitis were discovered (fig. 2).

In the liver there was a diffuse active cirrhosis with marked disorganization of the lobular pattern and many areas of disintegration of liver cells. In the portal and central zones considerable inflammation was present. In these areas, lymphocytes and macrophages dominated the picture, but there was also proliferation of fibroblasts and scattered foci of leukocytes. Eosinophils were absent. A notable feature was the presence of a dark brown pigment within the liver cells and the stroma of the liver (fig. 3). These stained positively for iron and the same phenomenon of iron deposit was present in the sections of the spleen, pancreas, the duodenum, and lungs. In the pancreas iron was found both in the pancreatic acini and in the islet cells. In the lungs it was present mostly in the free macrophages. A closer study of the liver indi-

cated that in addition to the cirrhosis and the pigment there were many areas of bland liver cell necrosis; in some of these zones, the liver parenchyma was reduced to ghostly remnants. Reparative inflammatory reaction occasionally was present. In the zones of cirrhosis, newly formed bile ducts were easily identified.

Summarizing the post mortem findings, we have here an example of hemochromatosis of the liver with pigment cirrhosis; iron deposit in the spleen, pancreas, duodenum, and lungs; a terminal uremic pneumonitis as indicated by the edema, congestion, and the fibrin-like formation in the pulmonary alveoli; and in addition evidences of a long-standing type of interstitial and yet active pneumonitis of a nonspecific nature insofar as any histologic patterns for specific infections are concerned. It was our feeling that we had here an instance of latent idiopathic hemochromatosis which was triggered by the occurrence of a viral type of pneumonitis which in turn produced effects on the liver comparable to a viral hepatitis; and following this the factors controlling the degree of the hemochromatosis were dissipated and the patient went on to a fulminating development of this idiopathic disorder leading ultimately to pigmentary cirrhosis and finally complete hepatorenal failure with its terminal complications.

Discussion

Doctor Rice: I take it, Doctor Enzer, that just as there was no evidence clinically of diabetes, there was no evidence anatomically of diabetes.

Doctor Enzer: That is correct. Although the pathologist is so often not able to either diagnose or eliminate diabetes, it can be stated that in the post mortem material there were none of the stigmata of diabetes.

Question: Doctor Enzer, can you establish beyond doubt that virus infection caused the changes you demonstrated in the lung sections?

Doctor Enzer: No, the opinion to that effect rests on the structural changes and the absence of other demonstrable causes for the pulmonary pattern.

Question: Does hemochromatosis or cirrhosis of the liver cause pulmonary pathology of this kind?

Doctor Enzer: Since the lung disorder was bilateral and was present before the development of frank liver disease, it would seem reasonable to eliminate displacement of the diaphragms upward as a factor. I am unaware of any infiltration in the lung produced by hemochromatosis or cirrhosis of the liver. Doctor Moel, what is your opinion?

Doctor Moel: I agree. As a radiologist, I am unfamiliar with any x-ray pulmonary pattern associated with cirrhosis of the liver except for the effects of ascites and finally pulmonary edema and congestion.

Question: How do you classify the hemochromatosis in this case?

Doctor Enzer: Doctor Fodden will discuss this aspect.

Question: Doctor Enzer, would you explain why you consider the liver to have been affected by a virus infection? And, do you think this man had a viral hepatitis in the generally accepted sense?

Doctor Enzer: The suggestion that the liver was affected by a virus infection was prompted by the inflammation evident in the liver, the zones of hepatocellular necrosis, and the rapid course of the liver disease. Whether this was epidemic viral hepatitis I cannot say, but I would consider that a reasonable possibility, since we do find evidences of pneumonitis in virus hepatitis.

Doctor Enzer: Doctor Fodden, we have time for a brief discussion of the nature of hemochromatosis not associated with diabetes. What do you think of the idea that in this case the hemochromatosis was activated by an intercurrent infection?

Dr. John H. Fodden: Doctor Enzer, the mysterious nature of this disease process makes your question a difficult one to answer. However, it prompts a considered opinion, and the facts of this particular case readily allow of such. I am confident that we have the morphologic evidence of hepatitis and that we must not look upon it as mere coincidence. Yet, to work it successfully or logically into our over-all interpretation is more than I can do. But, in this effort I will gladly subscribe to two separate interpretations; one, that this ever-present error of metabolism was made manifest, triggered, or "activated" by the hepatitis. We have ample suggestive evidence in the field of metabolic disease that such inflammatory activation is by

no means exceptional. The processes or mechanisms by which this is accomplished have not yet been explained.

My second interpretation is the belief that hepatocellular disturbance by virus infection may have been the actual primary cause of the metabolic dysfunctions whose evidences are so well presented. In other words, here was no actual "inborn error" but a disease process created and set in motion by disturbance or disruption of highly selective or complex cell functions. Every day we are learning more about the unfortunate ability of virus chemistry in this particular direction. Moreover, I am sure you will agree that of all the multiple, diverse, chemical functions of the hepatic cell, its chemical participation in iron transport and storage is not likely to be its most delicate or complex function; it does not impress as too subtle a target for a specific chemical insult. I feel sure that given the correct set of stimulating chemical (inflammatory) circumstances this function may be disturbed, perhaps crudely along with other functions, perhaps selectively so.

Again, the actual mechanisms damaged or abnormal ones instigated are the true roots of this problem. Hemochromatosis, no matter into what category we may place examples or to what symptom complex it may largely contribute, is entirely a "chemical" disease (if I be allowed the term) and will require similar explanation. This latter is the subject for many an attractive surmize, all of which now invoke some phase or phases of our recent knowledge of plasma-iron absorption and transport mechanisms. It may be as crudely simple as abnormal hepatogenic plasma proteins with exaggerated qualities of iron binding and transport facilities, and to which the selective absorption mechanisms in the intestinal mucosal cells have no responsive measures. It may be as complex as the enzymic failure of the sick hepatic cell to disrupt transferrin and allowing the latter's persistence as a ferric prosthetic protein in or upon the hepatic cell substance; or to be relegated as a chemically "unrecognized" intruder to those cells receptive of such, the sinusoidal Kupffer cells.

Doctor Enzer: Doctor Fodden has introduced another interpretation, namely, that the entire illness was the result of a virus infection and not related to a pre-existing disorder of iron metabolism. This would be a most attractive explanation if we had any evidence of complete metabolic and hepatic integrity prior to the onset of the illness. As in so many cases involving multi-faceted and complex problems one is left with stimulating ideas rather than complete answers. That, after all, is what is important about conferences of this type.

THE AMERICAN CONGRESS OF PHYSICAL MEDICINE AND REHABILITATION

The thirty-seventh annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held August 30–September 4, 1959 inclusive, at the Hotel Leamington, Minneapolis.

Scientific and clinical sessions will be given August 31, September 1, 2, 3, and 4. All sessions will be open to members of the medical profession in good standing with the American Medical Association and/or state or county medical association.

Full information may be obtained by writing to the Executive Secretary, Dorothea C. Augustin, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Illinois.

The American Congress of Physical Medicine and Rehabilitation conducts an annual essay contest and also sponsors the Bernard M. Baruch Essay Award. These contests are open to medical students and students in the field of physical medicine and rehabilitation. Awards are presented to persons submitting essays on any subject in the field of physical medicine and rehabilitation who have been selected by the Congress Committee on Essay Award as the prize winners. Further details on these contests will be found elsewhere in this issue.

Comments on Treatment

Editors—F. E. SHIDEMAN, M. D., University of Wisconsin, Madison
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The Placebo Effect

Dorland's medical dictionary defines a placebo as "an inactive substance . . . formerly given to please or gratify a patient, now also used in controlled studies to determine the efficacy of medicinal substances." The implication is that a placebo is inert. This is far from true. It is therefore no paradox to discuss the pharmacology of placebo.

A number of observations demonstrate the more than occasional influence of a placebo. For example, 40% of a group of patients with osteoarthritis were relieved of pain by a placebo alone. During a study of the effect of tolbutamide (Orinase) on the blood sugar in diabetics, 62% had good or moderate control while taking only the placebo. In two separate studies of treatment in chronic rheumatoid arthritis about one-third of the patients had both subjective and objective improvement while taking the placebo. In another study a nauseating dose of syrup of ipecac was administered to a group of volunteers. About one-third of these people did not become nauseated when "premedicated" with a placebo. Only slightly better than the placebo was a tablet widely advertised to the profession as a potent antiemetic!

A placebo was found to be therapeutically effective in from one-fourth to one-half (average 35%) of more than 1,000 patients having such diverse disease states as severe postoperative wound pain, cough, angina, headache, seasickness, and the common cold.[1]

The effects of a placebo are not solely subjective. Objective changes in the heart rate, blood pressure, blood sugar, gastric acidity, pupillary diameter, serum electrolytes, hormone levels, and serum neutral fat content have been measured repeatedly in groups of patients taking a supposedly "inert" substance.

There is also striking evidence of the "toxic" potentials of a placebo. In a "double-blind" study of the toxicity of streptomycin in a tuberculosis hospital, 61% of the patients receiving the placebo alone had various toxic reactions including eosinophilia, high and low tone hearing loss, and even impairment of urea clearance. Various investigators have found "side effects" such as dry mouth in 7%, nausea in 10%, and drowsiness in 50% of subjects taking only a placebo.

There is a tendency to believe that a placebo affects only mild or "imaginary" pain in people who are "neurotic." This is clearly not the case. Severe pain is relieved by a placebo as often as mild pain. A placebo may completely relieve pain of "organic" (*e.g.* carcinoma of the pancreas, postoperative wounds) origin. People who respond to a placebo are commonly not overtly neurotic, illiterate, unsophisticated, whiners, nor "bad" patients. Furthermore, it has not been possible to predict which person will be a "placebo responder."

The relief of a symptom by a placebo tells the physician nothing about the symptom's source nor its severity. The response to a placebo carries with it nothing of psychiatric diagnostic significance. Thus it follows that no useful information is gained by administering a placebo to an individual patient.

The placebo effect greatly influences the evaluation of drugs.[2] It is the explanation for brilliant therapeutic successes that cannot be repeated. It is responsible for honest but mistaken testimonials for a nostrum. It operates in our own practice whether or not we recognize it. In certain situations even potent drugs may act because of their placebo value. In this category vitamins, hormones, antibiotics, and tranquilizers are all too often included and are thus credited with undeserved worth.

A placebo may be "inert" but people are not.—J. D. KABLER, M.D.

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Alcohol Dependency—Disease or Dilemma

By EDWARD CARL SCHMIDT, M. D.

Milwaukee

MEDICAL progress in the last fifty years has moved so rapidly with the advent of immunization, vaccination, antibiotics, irradiation, and cardiac surgery that it would seem appropriate to review the progress man has made in the therapy of that common psychiatric disorder[1]—alcohol dependency.

In combatting any disease we must first define the illness so that we may have a target for our therapeutic efforts. On attempting to do this with alcoholism we discover that we run into conflict among observers much earlier than is true with most medical problems.[2] The first notable difference of opinion occurs over the question of whether alcohol dependency is an illness. A fractured leg, pneumonia, or diabetes we can all agree upon —these are diseases. Recent history provides us with insights into the delays in progress which occur when prejudice, superstition, and moralizing cloud our evaluation of a problem. Not too many years ago tuberculosis was felt to somehow be related to filth or immorality and carried some stigma. Syphilis, although being wiped out by antibiotics, is still not a generally acceptable topic of discussion in polite lay groups. Actually a catastrophic war with its concomitant collapse of unrealistic moral concepts, as demonstrated by the introduction of mass prophylactic stations and venereal disease education, was necessary to produce any real progress in the eradication of this age-old scourge.

In each disorder where moral or prejudice-ridden overtones enter thinking on a given problem, progress is inevitably delayed. Until epileptic or mentally defective children were permitted to emerge from the confines of the rear bedroom or attic, no progress was made toward the alleviation of their disabilities. Thus with alcoholism, moralistic or authoritarian approaches can only delay any improvement in our handling of the problem.

It might be of value to consider what has been said about the alcohol problem in years gone by, so we may provide an historical back drop for our thinking.

Nearly two thousand years ago Pliny (Lib XIV cap 22) wrote: "In the beginning there was water, then came the Flood, and there was too much water. There has been plenty of water ever since, for man and beast alike, for fish and grass, and all forms of life on the face of the earth. Yet," he continued, "if we look about us with some attention, we are bound to marvel at the enormous trouble which men take to have wine."

The first recorded alcoholic beverage in our western world is a wine, Noah's wine, called Yayin in Hebrew, and it is alluded to 141 times throughout the Holy Writ.

That problems existed, and a hint as to the reason for the problems in the dim past concerning alcohol, is evident from the Bible. Thus from Scriptural writing we learn:

> Challenge them not that love wine,
> For wine has destroyed very many.
> Fire trieth hard iron, so wine drunk to excess
> Shall rebuke the hearts of the proud.
> Wine taken with sobriety is equal to men, if thou drink it moderately, thou shalt be sober.
> Wine was created from the beginning *to make men joyful*, and not to make them drunk.
> Wine drunken with moderation is the *joy of the soul*, and *the heart*.
> Sober drinking is health to soul and body.
> Wine drunken with *excess* raiseth *quarrels* and wraths and many ruins.
>
> ECCLESIASTES, CHAPTER XXXI

The foundation book in the library of the Western World further provides us with keen insights into why, then and now, problems exist concerning the wise use of the universal sedative—alcohol.

Proverbs XXXI, 6–7 states: "Give strong drink to them that are *sad* and wine to them that are *grieved in mind*: Let them drink and *forget their want*, and *remember their sorrow no more*."

Mensetheus quoted by Athanasius the Greek has rendered in verse words on the alcohol problem:

> "Wine to our daily feasts bring cheerful laughter,
> When mixed with proper quantities of water;

Men saucy get if one-third wine they quaff;
While downright madness flows from half and half;
And neat wine mind and body too destroys;
While moderation wise secures our joys.
And well the oracle takes this position—
That Bacchus is all peoples best physician."

LAWS LIB I

Plato made the following remarks which would not be inappropriate from a Freudian analyst: "The soul of a man who is drunk returns to what it was when he was a child." And he adds: "No experiment is less costly, and none shall bear fruit more surely and quickly if we wish to test the characters of men, to judge them, and to be guided in the art of making them better, than to know them in the *truth of the drunk.*"

After centuries passed the alcohol problem was scrutinized by medical men, and one of the first publications dealing directly with it came from the pen of an American physician, Dr. Benjamin Rush, a foremost doctor and teacher of his time, who in 1785 wrote a scientific paper entitled: "An Inquiry into the Effects of Ardent Spirits upon the Human Body and Mind with an Account of the Means of Preventing and of the Remedies for Curing Them."

In 1788 Dr. Thomas Trotter submitted to the University of Edinburgh for his doctor's degree a thesis[3] entitled: "Essay Medical, Philosophical, and Clinical on Drunkenness," which caused such a stir that he received the thanks of the Royal Humane Society for his work. He defined alcoholism as follows: "In medical language I consider *drunkenness*, strickly speaking, to be a disease, produced by a remote cause, and giving birth to actions and movements of the living body, that disorder the functions of health."

In 1830 a report issued by The Committee of the Connecticut Medical Society stated that "the then current method of sending alcoholics to jail or workhouse was failing, and that before attempting to eradicate any DISEASE we should endeavor to investigate its character, to inquire into its nature and tendency and ascertain as far as practicable, the impediments which exist to its removal."

This trend toward medical consideration of the problem of alcohol dependency would tend to make us feel that the most informed thinking of the times was proceeding on the supposition that alcoholism was a disease, and thus a medical problem. Here we must pull up short, however, to reconsider the whole problem of the use of medications which tend to alter or impair consciousness. To begin we must consider terminology. The word *addiction* is defined as "the state of being given up to some habit." The term *dependence* is defined as the "total psychophysical state of an addict in which the usual or increasing doses of the drug are required to prevent the onset of abstinence symptoms."

Confusion has developed concerning the definition of terms in this field. The reason for the confusion is that rapid withdrawal of a sedative medication, be it alcohol, barbiturates, morphine, or bromides, produces a marked subjective feeling of anxiety which is identical to the feeling which the person involved utilizes sedatives to combat in the first place. All substances which have the power of reducing anxiety and awareness, including alcohol, morphine, barbiturates, and bromides, function to produce dependency in an identical fashion. The persons involved are similarly constituted, the action of the above-mentioned drugs are more similar than different. The only variation lies in the attitude of society toward the use of the medication. The user of morphine, or heroin, or marijuana pays for his attempts at relieving anxiety or producing conviviality by a jail term; while, despite the fact that the National Safety Council[4] reports that 55% of all fatal traffic accidents in the holiday season involve drinking drivers, the masses are encouraged on all sides to use alcohol, which is physically the most harmful of the addicting drugs. The paradox proceeds to a point so bizarre as to seek to determine from the alcohol content of the urine whether consciousness has been sufficiently impaired to lodge a charge of drunkenness and thus remove the occurrence from the realm of socially acceptable intoxication to criminally liable drunkenness.

Seneca[5] wrote in 50 A.D.: "Posidonius maintains that the word drunken is used two ways, in one, the case of the man who is loaded with wine and has no control of himself; in the other, of a man who is accustomed to get drunk and is a slave to the habit. You will surely admit that there is a great difference between a man who is drunk and a drunkard. He who is actually drunk may be in this state for the first time and may not have the habit, while the drunkard is often free from drunkenness." This 2,000-year-old observation may help us.

Keeping the social paradox in mind we must attempt to define alcohol dependence or alcoholism. Acute intoxication, delirium tremens, alcohol hallucinosis, in fact each entity short of Korsakov's psychosis and hepatic coma from cirrhosis responds readily to withdrawal of the sedative alcohol, so we need only concern ourselves with the disorder characterized by the "desire to drink" and "psychic effects of the drinking," and not be concerned with the undesirable and toxic side effects of the sedative alcohol.

Psychiatric Disorders

Before attempting to set into words our definition, it would be apropos to speak about psychiatric disorders in general. It might be agreed that the keystone of all mental disorders is anxiety, and that all psychiatric reaction patterns, of which alcohol dependency is one, are evidences of our varying personal techniques in handling this anxiety. But that this is not firmly agreed upon is evidenced by the varying attitudes of physicians, psychiatrists, clergymen, and the lay person toward the alcoholic. Generally the quite diverse theories and attitudes about the causes of alcoholism fall into three major categories which we can examine before we proceed toward consideration of our definition of alcoholism.

The first of these theories, held by the "wet group," dispensers and users, states that *the* cause lies in the individual's *deliberate* abuse of the privilege of drinking.

The "temperance group," second of these categories, has held that alcohol is the cause, and the only cause, of the problem known as alcoholism. The medical profession has tacitly approved this theory by handling narcotic addiction by legal means in the passage of the Harrison Narcotic Act. This law makes the individual giving himself morphine, cocaine, marijuana, or heroin a criminal and jails the seller. There is no major difference between alcohol and morphine or barbiturate addiction, except perhaps that morphine and barbiturates are less harmful physically to the user. A side light on whether alcohol is a drug occurs when we read of the permissive, jovial old physician prescribing increasingly frequent nips of brandy to "Old Widow Jones" for her hypochondriacal abdominal distress and anorexia, which he must feel are psychologically determined.

A *third major opinion* holds that alcoholism is caused entirely by the drinker's lack of will power and character. Analytically oriented psychiatrists may paraphrase this as a "character disorder" or a "lack of ego strength."

In many situations where there are several diverse opinions which seem diametrically opposed on a problem, the truth usually lies somewhere in the gray area between the black and white of opposing views, and sometimes each idea may have in it a part of the truth. Let us look carefully at each theory.

First the theory that alcoholism is due to alcohol makes us face up to the fact that history shows that every civilized group of people, from Australian bushmen to cultured Europeans, recognizes their need for reducing anxiety or producing artificial mental states on special occasions—social, religious, or strife-laden—by preparing alcohol or similar sedatives. It is a fact that alcoholism alternating with narcotic and barbiturate addiction is more common among physicians and pharmacists to whom these other agents for anxiety relief are more readily available. Probably general removal of alcohol (as by Prohibition) will not be permitted by the majority to protect the minority who get into serious trouble with the socially permitted drug.

The "wet group's" theory of every man's right to abuse a privilege ignores the aspect of whether the individual knows what he is doing or is capable of deciding on a reasonable course of action, when the mores which permit legal use of the sedative medication or alcohol may not apply to his psychological make-up under certain circumstances.

The theory involving lack of will power or character appeals to me most, but I think the defect in its use lies in the fact that we make it sound like a judgment rather than an objective scientific evaluation. The "joker" is in the word *lack*. This again introduces the social and professional paradox into our thinking. I think all would agree that each individual does his best to adjust to his internal strife and to the demands of the world around him in the form of his interpersonal relationships. I like to compare psychological adjustments to cardiac function. When a heart muscle is weak or scarred by disease or too heavily burdened, it may fail to adequately pump blood, and we have edema, dyspnea, and all the evidences of decompen-

sation. When a personality is weak, or scarred by hereditary or developmental deprivation, or too heavily laden by external stress, it may decompensate in similar fashion; and the symptoms of this decompensation we in psychiatry know as schizophrenia, anxiety neurosis, depression, or alcohol dependency. To be angry at the alcoholic's relapse is like being angry at the hallucinations of the schizophrenic, or the querulousness of the depressive, or the clinging dependency of the agoraphobic. It is akin to being angry at the dyspnea of the cardiac patient—and just as unreasonable. Sometimes we vent our hostility by coining names for people who decompensate by becoming alcohol dependent, and we categorize them as "psychopathic personalities" or "social psychopaths," knowing full well these terms with their condemnatory overtones really are targets for our own poorly channelled frustrations and hostilities.

An alcoholic is in no fashion, more or less, responsible for his attempts to alleviate his anxiety with alcohol than a schizophrenic is by means of hallucinations or delusions, or a person with an acute anxiety reaction is by the formation of phobias. In the life situation in which he exists at the time of its occurrence, alcoholism is his optimum solution,—to his way of thinking.

Eminent psychiatrists have called schizophrenia a way of living—the person's best adjustment under a given set of circumstances with his resources at a given time. Alcoholism could be similarily considered. Thus we have, to a degree, arrived at our definition. *Alcoholism is a reaction pattern, a way of living, in which an individual attempts to handle his anxieties by use of a socially acceptable sedative, alcohol, which in turn, by its ego disorganizing effect on him personally makes increasingly difficult his existence with society in the form of his family and community.*

As psychiatrists and doctors who treat the weak and sick, we can only try to aid the alcoholic patient in altering his reaction pattern or way of life, trying our best to remain in our roles as physicians and foregoing the role of judge.

Methods in Therapy

When the patient who is dependent upon alcohol or drugs comes to the hospital, he has usually been a victim of this reaction pattern[6] for a considerable period. He has used alcohol and drugs as a means of handling his anxiety under a given set of life circumstances. Now, because of a change in external circumstances, as perhaps a heavier work load, altered pressures in the form of additions to family, deaths of psychologically significant persons, intervening somatic disease, this sedated form of existence is no longer adequate. On the other hand, because of altered physiological functions always attending the long-term use of sedatives, such as disturbance in sleep pattern, change in food intake, and alteration in available libidinal energy, incident to physiological tolerance for the sedation, breakdowns may occur in an unchanged life situation. These are manifested as insomnia, deterioration in finer judgment, free-floating anxiety undiminished by alcohol, and ultimately delirium. When the patient is admitted to the hospital, he usually realizes from the above outlined disabilities that he is ill; and for a bit he is willing to be a patient. Once this situaton has pertained, the job of the therapist begins. The diagnosis of alcohol dependency has been arrived at, the patient has been removed from his home and work environment, and now all efforts must be immediately mobilized to convince the patient that his illness consists of not the results of the alcohol but of his inability to stop using it. Usually no measure short of a total break in daily routine and complete protection *under psychiatric supervision* will be of value, because if he could stop using alcohol in his existing life situation, he would probably have already done so. Chances are he has already tried a dozen times, unsuccessfully, to recover under the condition of "business as usual" with the medication which subjectively alleviates his anxiety most efficiently being used with impunity by all his acquaintances and relatives daily on all sides of him. Most alcoholics are anxious, shy, tense, introverted, dependent, sensitive people,[7] and so it will be that in the time of his greatest need, the emotional tension of social or work situations, he will be offered his panacea in a cocktail glass by a society which realizes all too well that most folk are socially more comfortable when their anxiety and awareness are clouded by a little sedation.

Since hospitalization is anxiety-producing and defeat in a fashion, he will be resistant to the last ditch. He will usually be under the effect of alcohol upon admission and hostile

to the world which wishes to deprive him of the sedative most everyone else enjoys or does not need. Treatment, to be successful, must hinge entirely on one central issue. *He must be convinced that alcohol dependency is a result of an emotional illness which needs treatment.* Here again alcohol and drug dependencies differ markedly from all illnesses, other than perhaps a few of the major psychoses.

A few schizophrenic patients, and they are the exception, will insist they are not ill, but the alcoholic will begin the day he is hospitalized to plan for his discharge, so that he may escape his physician, and more specifically escape his problem and resume business as usual. He has no complaints and is a "bad patient," or a "too good patient," because of his constant fight for independence. His therapy can be divided into two phases. Since his central nervous system is suffering from the cumulative noxious effects of the universal sedative, and his finer judgment and thinking ability are at low ebb, the first weeks of hospitalization must be devoted to repairing the damages wrought by alcohol.

Confusion has developed concerning observations in this specific time in therapy. The reason for the confusion is that withdrawal of a sedative medication (alcohol, morphine, barbiturates) produces a marked subjective feeling of anxiety, which is identical to the feeling for which the user takes alcohol to combat in the first place. Thus the cause of the dependency, and the results of its withdrawal, have become confused in the observer's mind. It takes about one month for a heavy user's central nervous system to return to its normal level of excitability (basic anxiety level); and thus many alcohol and drug-dependent people never really get to work on basic problems, but experience many short hospitalizations, usually being given other sedatives while hospitalized, so they are constantly struggling with the anxiety feelings of withdrawal, rather than the major problem of the situations producing dependency in the first place. It is rare that a heavy alcohol or sedative user re-establishes anything approximating his normal drug-free patterns of sleeping and eating and working in less than six to nine weeks after withdrawal of the offending medication. Unless the physician is successful in convincing the patient he is sick, and thus needs time to recover, early discharge while experiencing the anxiety of withdrawal will make cessation of the anxiety-alcohol, withdrawal-alcohol pattern improbable.

Since in recovery from alcohol or drug dependency the most important factor the therapist has working on his side is the undrugged ego strength of the patient, he must quickly set his goal to obtain, for his patient and himself, adequate time for this undrugged ego to reorganize itself. He should never allow the patient's happily prompt recovery from the acute ravages of alcohol to lull him into happy disregard of the long-term malignancy of the disorder. It is this practitioner's belief that on no occasion should a patient have prescribed for him, as in the gradual withdrawal philosophy, the identical preparation, be it alcohol or sedative drugs, whose use has created the complex problem. Patients are intuitive, and if on this occasion we agree he needs a little help from the substance which will in the long run destroy him ("hair of the dog"), how can the therapist at a later date, during similar anxious episodes, sincerely deny it to him completely?

The physical state of the patient must be promptly attended. Diphenylhydantoin sodium, in doses of 100 mg. three times daily, gradually tapered to none in the course of two to three weeks, will serve to prevent withdrawal seizures. Sleep the first nights should be assured, using a sedative with which the patient is unaccustomed. Daytime sedation can be procured with a barbiturate plus a tranquilizer (elixir of carbromal, 5 ml. three times a day, and meprobamate, 400 mg. three times a day). Given the first few days of withdrawal, lipoadrenal cortex, 1 cc. intramuscularly daily for three or four days, has seemed to prevent delirium. The patient should be given vitamins B_{12} and crude liver extract intramuscularly, first daily, later tapering to weekly to benefit the somatic state, but also to create the psychological framework of treatment for a severe illness which is not over because the acute episode is under control, and to aid in providing patient and physician with time. The tentative goal of having the patient free of all sedative medication within two weeks of total alcohol withdrawal, with individual variations dependent on anxiety level, has proved workable and can be applied to most patients.

The therapist intimates by speech and action that he considers the treatment proper for the alcohol or drug-dependent patient to begin on the day he functions first in the hospital free of alcohol and all medications of an anxiety-alleviating nature. Queries concerning medications for the relief of tension are honestly met with the statement that individuals becoming dependent or addicted to one sedative possess a personality structure and metabolic structure making them, in general, easily prone to addiction to any sedative preparation, so that the patient comes early to understand that the doctor feels that the goal must be total abstinence from *all* sedatives.

Psychotherapy

Psychotherapy begins on first contact with the patient and is directed early toward the primary goal of attempting to convince the patient that he is ill, and that this illness consists of his inability to exist without alcohol or drugs under his present life circumstances. The therapist may take the position that this is a very difficult disorder from which to recover, but that his patient may recover if he can admit he is ill and work constructively to understand and combat his illness. Relapses may occur but are understandable. They do not mean all is lost, and especially will not enrage the therapist.

It has proven of some value to make these early days *a time of change* in order to mark a separation point between the old alcohol-dependent and the hoped-for new alcohol-free way of living. The day alcohol use was stopped can be made to coincide with daily changes in almost unconscious acts like the brand of cigarette used, style of coiffure, adoption of a new activity, such as recreational outlets providing ego satisfaction and of sufficient interest in themselves to provide crevices in the patient's daily life for self-expression and freedom from anxiety. Physical sports such as golf and tennis and artistic endeavors of a creative order such as ceramics, painting, and woodworking have seemed of great value to some patients. In the main, these forms of therapy have seemed helpful when they allow original self-expression and experimentation and stem from the patient's inner interests and talents. Rarely have monotonous activities serving to pass time, such as involvement in knitting or repetitive leathercraft chores, seemed to indicate more than resignation, and thus have marked for us the patients with the poorest prognosis. Any sort of interest or activity outside the patient's usual pattern of life should be encouraged to the hilt no matter how bizarre or trivial-seeming, since, as in all psychiatric disorders, improvement seems to be dependent upon the occurrence of change, spontaneous or induced.

Patients succumbing to alcohol dependence are often not getting adequate ego satisfaction from their daily lives. This is borne out by the rapture experienced by a big business executive over an original ceramic piece personally produced, or the satisfaction felt by the mother of five over a water color, personally done, of a lake scene she knew as a child. Although inconsequential-seeming, it is possible that these ego satisfactions experienced first during a hospitalization for an alcoholic dependency episode may, if pursued, mean the difference between a productive existence on recovery from alcoholism on one hand, and a downhill course to destruction or suicide on the other.

Since anxiety springs from interpersonal relationships, and these exist most intensely between the alcoholic and his loved ones, visitors should be kept away or at a minimum during the first two to four weeks of hospitalization. It has been observed that alcoholics may "drink at" certain people (husbands, wives, bosses), and that often mates of alcoholics behave in fashions calculated (unconsciously) to perpetuate the addiction in the partner, so the therapist should introduce these close persons into the picture only at such times as the patient is beginning to become aware of the dynamics of his illness, so that the partner does not unconsciously sabotage the entire program. Usually the mate or parent of the alcoholic will benefit by psychiatric therapy concomitant with the alcoholic patient. Ideally the same therapist should treat both, and he can manage it comfortably if he avoids identifying excessively with either. The interdigitation of the alcoholic and his partner's psychological problems usually is visible early to a single therapist, while two therapists tend to overlook this, and thus be unaware of the hazards each partner will face incident to psychiatric change in the other.

The patient is never willingly discharged until he has been alcohol and sedative-free for two months. There are no criteria for optimum time of discharge, but it should not

occur until the patient has made some major changes in his life situation (*i.e.*, job change, divorce, etc.) or gained definite insight into the unconscious conflicts producing his anxiety, or preferably both. Hospitalization should in all instances be followed by outpatient psychiatric therapy.

Results of Therapeutic Regime

The author has used as research material a group of 20 alcohol and drug-dependent patients, admitted on his service to a 150-bed private psychiatric hospital in a two-year period, and treated in the fashion outlined above. In this group of 20 patients, 12 were males, and 8 were females. All but 2 of the males were married, and only one of the females was single. After withdrawal of alcohol and observation, 2 of the 20 were felt to be psychotic, while the remainder suffered from psychoneurotic anxiety reactions of moderate to severe degree. While the ages of the patients varied from 29 to 66, over 50% were being hospitalized initially for alcohol dependency in the fourth decade. It seemed as though females came to hospitalization later than males by 5 to 10 years. The involutional period seemed to coincide in females with development of alcohol dependency. All the patients had consumed alcohol socially and in moderation for many years prior to the development of alcohol dependency. The physical conditions of the 20 patients, general and neurological, were average for the age group after the results of the chronic alcohol intoxication had cleared. These patients have remained in the hospital in varying periods from 5 to 120 days. They have received psychiatric observation and therapy with each being seen in consultation a minimum of one-half hour every two days during their hospital stay, while efforts at planned, progressive, goal-directed, psychotherapy were made. These patients were circularized a minimum of three months after discharge to determine their status, and if possible to learn if they felt their hospital stays had been of any value, and if so, what aspects of treatment had been valuable. Since no patient was in a continued relationship with the therapist, the answers given on the follow-up questionnaire should not be influenced by a potent transference phenomenon, nor had the patients who answered any evident ulterior motives leading to untruthfulness. The questionnaire was sent directly to the patient, and in no instance was a third party informed as to the questionnaire by the author. There was no reward attached to cooperation on the questionnaire, nor reality existent punishment involved in failure to cooperate. The questionnaire did not assume the patients had recovered from their illness, in fact it probably leaned toward indicating that the patient might be having some difficulty, so as to attempt to provide a climate friendly to honesty and reality-facing. Of the 20 patients circularized, 12 patients responded, one of whose questionnaires was returned by a relative who indicated that the patient had committed suicide eight months after release from the hospital. The conditions of the 8 who did not answer were assumed to be unimproved or worse.

The responses of the remaining 11 are summarized as follows: To the question as to whether they felt well and productive, 11 answered "yes." All 11 continued to live at home with their families. All 11 were working full time. Two were under psychiatric treatment. One used alcohol to excess two times monthly. This same patient used sedative medications to excess occasionally, but less frequently than prior to hospitalization. Three had not used alcohol since the hospitalization. Six used alcohol in moderation socially, apparently to a degree not objectionable to their mates or associates. One who had gotten into severe difficulty with a combination of alcohol and glutethimide (doriden) used small doses of prochlorperazine (compazine) under medical supervision. Nine were under no psychiatric supervision or care; one was under general medical care. To the query as to whether they felt their excessive use of alcohol and/or sedatives was evidence of an emotional illness, 8 answered in the affirmative. Of the 2 who felt they were not ill when hospitalized, one stated she felt she was physically ill. To the question as to whether the hospital experience was of value, the 11 who responded stated that it was. One might conclude that the 8 patients who did not respond assumed their hospitalization was not of value, and in all probability was forced upon them by outside pressures; and they were continuing to resist outside pressure in the form of the questionnaire. The following are the answers the respondents gave to the query "in what fashion was hospitalization of value?"

"Detached contemplation—and as a threat against future stupidity."
"My general health was much improved."
"I got time for mental reflection and reestablished emotional balance."
"Gave me a new slant on the problem."
"Everyone was kind and I seemed to regain self-confidence."
"Feel fine—thank you very much."
"Gave me a chance to re-evaluate living."
"It gave me a chance to re-establish my physical health."
"It was helpful for my mental confusion."
"It gave me confidence and a better insight into my problem."
"I got a long look at my life."

Conclusions

Alcohol dependency is an event occurring in the life of a patient suffering from a psychiatric illness. In 90% of patients this illness is a chronic anxiety reaction. In the remaining 10% the dependency occurs concomitant with the development of a psychotic reaction. This reaction is usually depressive in nature and seems to be most frequent in involutional females.

Fifty per cent of patients hospitalized for the treatment of alcohol dependency subjectively gained benefit ranging from total abstinence in 2, to minimum occasional social alcohol consumption in 8.

If we can assume that those patients responding to the questionnaire are those whose status was improved by hospitalization and that those failing to respond were those whose status was unchanged, the following facts become evident: There was no patient in the improved group who either failed to make some major change in his life situation, or was felt by the therapist to have failed to gain some understanding of the dynamics of his chronic anxiety neurosis. No patient in the improved group was hospitalized less than 30 days, while 4 of those in the unimproved group left against advice after periods ranging from 5 to 18 days. On the other hand, mere duration of hospital stay without the occurrence of major change in life situation or the acquisition of insight in therapy was of no value in itself, since the average hospital stay in this small series was almost the same in each group.

This author feels there is nothing unusual in the alcoholic's response to alcohol itself in a chemical fashion, although individual preferences for sedatives must in fact have a physiological basis in the organism. It is his feeling that the general social acceptance of alcohol consumption aggravates the problem of the alcohol-dependent patient. Under ideal conditions it would seem the alcohol-dependent patient can best be treated psychiatrically in a framework in which the patient may be switched from outpatient to inpatient status with a minimum of difficulty on the decision of the psychiatrist. Outpatient clinics attached to hospital units with beds, available to the outpatient psychiatrist, would be of value. Utilizing maximum flexibility, including day or night hospitalization patterns as the need occurs, with no break in the continuity of treatment by the psychiatric staff, could well result in the recovery of a higher percentage of alcoholic patients.

In general it might be stated that alcohol and/or drug dependency usually conceals a psychiatric illness, usually an anxiety neurosis sometimes a psychosis, occasionally a transient situational reaction that needs to be treated successfully in order to aid in recovery from the secondary alcohol dependency. Extreme flexibility must remain the hallmark of therapy, and every conceivable therapeutic adjunct can be utilized, but psychotherapy will remain the essence of the treatment process.

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Traumatic Rupture of the Diaphragm with Immediate Diaphragmatic Hernia*

By WALTER T. BECKER, M. D.
Wausau

TRAUMATIC diaphragmatic hernia is an injury which is said to be increasing in frequency, due principally to the increase in crushing injuries occurring as a result of automobile accidents. These acute ruptures of some portion of the diaphragm are due to: (1) direct injury, occurring at any point, usually the result of a penetrating wound from a gunshot or a stab wound; and (2) indirect injury, most often occurring in the dome and posterior half of the left side of the diaphragm, the result of severe crushing injury.[1] At the time of the rupture of the diaphragm, or sometimes thereafter, the semi-elastic recoil of the lungs and positive pressure in the abdomen may cause a movement of abdominal contents into the thorax.[2]

In the direct type of injury the rent may be at any point in the diaphragm. Here, if the wound is small, herniation may be long delayed or go unrecognized for months and years without producing symptoms. In crushing injuries, the rent in the diaphragm is usually larger and the herniation will tend to occur sooner, in most cases almost immediately. This was the situation in the two cases the subject of this report. Traumatic diaphragmatic hernias occur on the left side in 90% to 95% of all cases. The liver protects on the right side, but occasionally it will be the migrating organ, with or without some portion of the intestinal tract. On the left side the most common viscera involved are the stomach, small intestine, colon, and spleen.[3] The pancreas and left kidney have been reported in diaphragmatic hernia. (Fig. 1)

The symptoms of this condition will vary according to the severity and extent of the rent in the diaphragm, and the rapidity of the migration of abdominal contents into the thorax. Three stages have been described:[4]

1. *Immediate:* Here other injuries may mask the condition; a small defect may be temporarily plugged by omentum, liver, or spleen. If the rent is large and immediate herniation occurs, there will be severe pain in the left chest or left upper abdomen. Dyspnea and cyanosis will usually be present. Symptoms of shock will supervene with low blood pressure and rapid, weak pulse. Examination at such a time will generally show increased resonance in the upper left chest with dullness and absence of breath sounds in the lower chest. Mediastinal and cardiac shift to the right occurs in almost all cases of this type. Bowel sounds may be heard in the thorax.

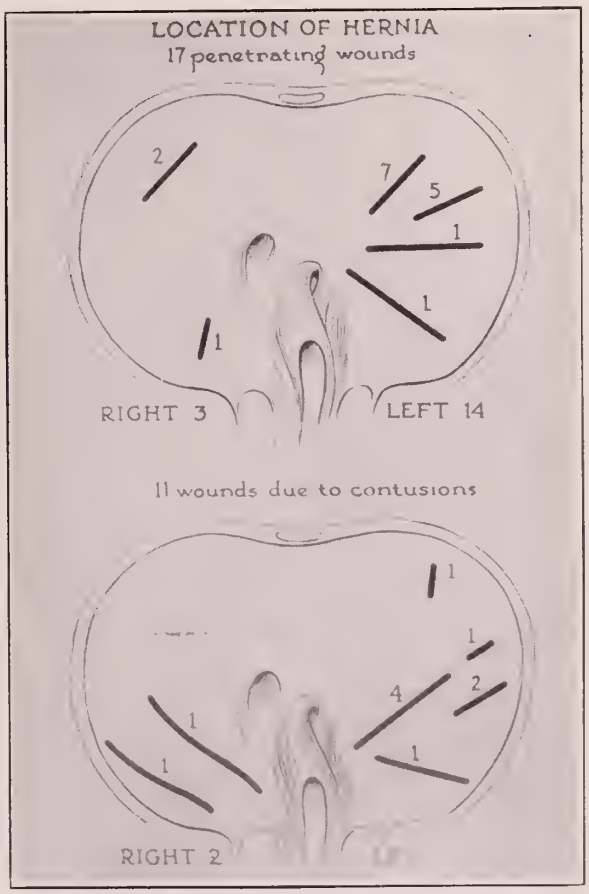

Fig. 1—Diagram. (Reprinted, with permission, from Hughes, F. A.: Location of hernia. J. Thor. Surg. 17:99–110 (Feb.) 1948.)

* Presented at meeting of the Wisconsin Surgical Society on September 20, 1957, Madison, Wisconsin.

2. *Interval:* If recovery from shock has occurred, the patient may become more comfortable and seem to recover. This stage may last from a few hours to months or even years. There may be mild dyspnea and vague gastrointestinal symptoms.

3. *Obstruction and Strangulation:* This may occur rapidly, in a few hours or days, or may be delayed for months or years. If delayed, it may be precipitated by strenuous bodily activity, overeating, trauma (even of minor degree), straining on defecation, postoperative distention, pregnancy, and parturition. Obstruction and strangulation will occur sooner and more readily if the defect is small, as in stab wounds. Torsion of herniated organs may also occur. Pain in obstruction and strangulation is severe and is not relieved by vomiting. Hematemesis may occur. There may be symptoms of small or large bowel obstruction, but these will not occur if only the stomach is herniated. Stress ulcers or gangrene may occur and may lead to perforation of herniated organs.

The diagnosis is made by the history, physical examination, and roentgenologic findings. Physical examination may reveal the findings described above, or there may be only relatively normal findings in early cases. There may be positive physical findings in the opposite chest in those cases where the herniation has been into the mediastinum or where the mediastinal pleura has been lacerated. If this occurs, mediastinal shift will not be a prominent finding. There may be evidence of other trauma in the abdomen, such as rupture of the spleen. This is an uncommon finding, but occurred in one of our cases. Physical examination should be repeated often when initial findings are few.

Roentgenologic examination may not reveal any abnormalities early. Carter and Giuseffi have emphasized that fluoroscopy is generally of great help, especially with barium introduced into the stomach through a nasogastric tube, or into the colon by barium enema.[4] The most significant roentgenologic findings are: (1) an arch-like shadow resembling an abnormally high diaphragm; (2) extraneous shadows such as gas bubbles, homogenous densities, or other abnormal markings extending above the anticipated level of the normal diaphragm; (3) shift of the heart and mediastinal structures to the right; (4) disk or plate-like areas of atelectasis in the lung superjacent to the arch-like shadow.[4] Lateral recumbent films may help to differentiate free pleural fluid. Barium introduced into the stomach or colon may be prevented from entering or leaving the herniated organ by obstruction, thus causing confusion. The herniated viscus may simulate the diaphragm in both lateral and anteroposterior projections and lead to a diagnosis of eventration of the diaphragm.

In the differential diagnosis of traumatic diaphragmatic hernia the following erroneous diagnoses are most often made: eventration of the diaphragm, pneumonia, atelectasis, intrathoracic cyst or tumor, pleural effusion or empyema, subdiaphragmatic abscess, pneumothorax, or hydropneumothorax. The pain of traumatic diaphragmatic hernia may be simulated by that occurring in pulmonary embolism, coronary occlusion, biliary colic, acute pancreatitis, perforated peptic ulcer, or mesenteric thrombosis.

The treatment of traumatic diaphragmatic hernia is surgical. Operation should be performed as soon as the diagnosis is made and the condition of the patient allows. When obstruction and strangulation are present, immediate operation is essential. When these are not present, time may be taken to bring the general condition of the patient to the optimum state for surgery. Anesthesia must be given by the endotracheal technique in order to control respiration and to inflate the lung as necessary. The thoracic approach is generally the most desirable, but suspicion of concomitant intraabdominal injuries may make the thoracoabdominal route best. Surgical treatment consists in replacing the herniated viscera into the peritoneal cavity and repairing the rent in the diaphragm.[5] The repair is best made with silk sutures, overlapping the torn edges of the diaphragm if possible. In the presence of frank infection, such as will be encountered after perforation of a herniated organ, chromic catgut is preferable to silk. Temporary paralysis of the diaphragm by means of phrenic crush may be carried out if desired, but is not essential in these cases.

Postoperative care requires gastric suction and suction or under water drainage for the

catheter in the thorax. Rather complete rest is important in the early postoperative period to avoid anything that would tend to increase the intraabdominal pressure.

Case Reports*

Case 1—G.R., a 2-year-old white male child, was admitted to St. Mary's Hospital after having been struck by a truck. There were no witnesses except the truck driver, and it is not known whether any truck wheel passed over the child's body. The child was conscious but appeared to be in shock. He was restless, crying, and had labored respirations. He was pale and there was cyanosis of the lips. The pulse was weak and irregular. There was a contusion to the left forehead, and a large abrasion of the left side of the abdomen extending to the flank. There were multiple abrasions of the extremities but no deformity and no evidence of bony injury. The pupils were equal and reacted to light. There was no bleeding from the nose, ears, or mouth. The neck was not rigid and motions of the neck were not painful. Expansion was limited on the left side of the thorax. The heart and mediastinum were shifted to the right. There was dullness to percussion over the left hemithorax. Breath sounds were absent in this area. The heart sounds were weak and distant. The abdomen showed rigidity and tenderness in the left upper quadrant. There were no abnormal masses. Neurological examination was not remarkable.

X-rays of the skull showed no fracture. X-ray of the chest and abdomen showed the heart and mediastinum shifted to the right. The stomach appeared to be in the left chest. The lung was compressed above the stomach. No fractures of the spine were noted. (Fig. 2)

A diagnosis of diaphragmatic hernia was made and operation was performed two hours and twenty minutes after admission. Premedication consisted of ¼ gr. of codeine and 1/400 gr. of atropine. The anesthetic consisted of cyclopropane induction followed by endotracheal ether. The abdomen was first explored through a left paramedian incision. There was no blood in the peritoneal cavity and no evidence of trauma to the intraperitoneal structures. The stomach was seen to be herniated into the left chest. Reduction from below was not successful. Accordingly, the incision was extended through the left eighth intercostal space, opening the left chest. The entire stomach, spleen, splenic flexure of the colon, and a portion of the transverse colon were present in the chest cavity. There was no hernial sac. The herniated organs showed no evidence of local trauma. They were replaced into the peritoneal cavity. The diaphragm showed a laceration three inches in length beginning posteriorly at the lateral chest wall and extending forward and medially. The rent was repaired with interrupted and continuous chromic catgut sutures. A catheter was inserted into the left pleural cavity through a stab wound. Chest and abdominal wounds were closed. Suction was applied to the catheter which was removed on the sixth postoperative day. Gastric suction was instituted and antibiotics administered. Divided transfusions of 500 cc. of whole blood were given. A fracture of the pelvis, inadvertently missed on the first x-ray films, was treated in the postoperative period with traction and a hip spica cast. The cast was removed on August 17 with evident healing of the fracture. Because of poor home conditions the patient remained in the hospital until September 16 and was discharged in good condition. Fluoroscopy on December 7, 1956, showed normal motion of both leaves of the diaphragm. The child has remained well until the present time. (Fig. 3)

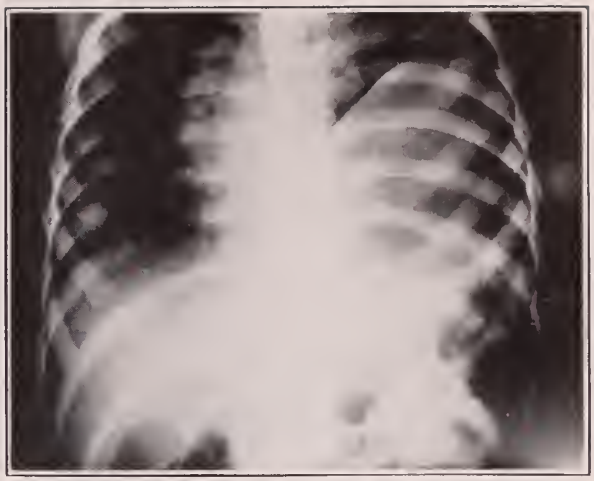

Fig. 2—Case 1, G.R., age 2. Roentgenogram taken on admission, July 3, 1956. Elevation L leaf of diaphragm. Mediastinal shift to right.

* Acknowledgement is made to Dr. G. H. Stevens, attending physician in Case 1, and Dr. J. V. Flannery, attending physician in Case 2, for the correct diagnoses and assistance in treatment of these cases.

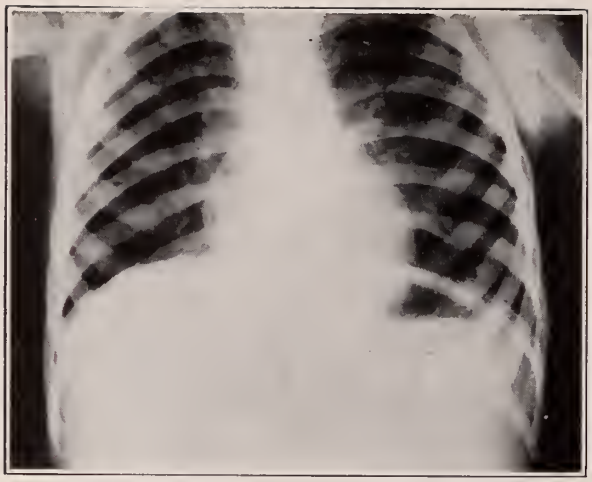

Fig. 3—Case 1, G.R., age 2. Roentgenogram taken July 31, 1956, showing chest to be normal.

Case 2—M.P., an 18-year-old white female, was admitted to St. Mary's Hospital on July 28, 1956, after an auto accident. She was the sole survivor. Five persons, including her parents and brother, had been killed. The patient was conscious on admission but recalled no details of the accident. She stated she had been asleep before it occurred.

Fig. 4—Case 2, M.P., age 18. Roentgenogram taken on admission, showing Levin tube in stomach above diaphragm, with small amount of barium.

Fig. 5—Case 2, M.P., age 18. Roentgenogram taken day before discharge, August 9, 1956.

She complained of severe pain in the left chest and abdomen and pain in the right upper arm. She had moderate difficulty in breathing. There was an abrasion of the face with ecchymosis about the left eye and edema of the left side of the face. There were contusions and abrasions of the left chest and abdomen, both hands, and the right knee. There was an obvious fracture of the right humerus. There was dullness to percussion in the left lower chest and the mediastinum was shifted to the right. Breath sounds were present in the upper left chest, but absent in the lower chest. The abdomen was rigid, with exquisite tenderness in the left upper quadrant.

X-rays of the right arm showed a severely comminuted fracture of the middle third of the shaft of the right humerus with displacement and overriding. Roentgenograms of the chest showed the heart and mediastinum displaced to the right, a fracture of the left sixth rib, and a large collection of air in the left lower chest. In a later film and with fluoroscopy, the diaphragmatic hernia was seen. (Fig. 4)

Operation was performed eight hours after admission. Premedication consisted of 25

mg. of meperidine hydrochloride and 1/200 gr. of scopolamine hydrobromide. Intratracheal cyclopropane was used for anesthesia. The abdomen was first explored through a left paramedian incision. A large amount of blood was present in the peritoneal cavity. The stomach, spleen, and splenic flexure of the colon were herniated into the left chest cavity. The incision was extended through the ninth intercostal space and the thorax opened. The spleen was badly lacerated. It was replaced into the peritoneal cavity along with the stomach and colon. Splenectomy was then performed. There was no intrinsic injury to the stomach, colon, or other abdominal organs. The laceration of the left leaf of the diaphragm was then repaired with interrupted mattress sutures of heavy silk. A catheter was inserted into the left chest through a stab wound. Chest and abdominal wounds were closed. Before and during the operation, 3,500 cc. of whole blood was given. Gastric suction and suction to the chest catheter were maintained. Antibiotics were administered. The patient made an uneventful recovery. The catheter was removed on the fourth postoperative day. (Fig. 5) On the eighth postoperative day a hanging cast was applied to the fractured humerus. Traction treatment had preceded this. The patient was discharged on August 10, 1956. She has remained well, as reported by her physician in Champaign, Illinois.

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ANNUAL CANCER SEMINAR AT MILWAUKEE ON DECEMBER 6

The annual cancer seminar, sponsored by the Wisconsin Society of Pathologists and the Milwaukee Chapter of the American Cancer Society, will be presented on Saturday, December 6, at 1:00 p.m. at Marquette University School of Medicine. The Seminar will be on "Tumors of the Chest" and will be moderated by Dr. W. A. D. Anderson of Miami, Florida. There will be a morning session devoted to clinical pathology presented by the membership.

A limited supply of slide sets are available at $10 service charge. Requests should be directed to: Robert S. Haukohl, M. D., 561 North 15th Street, Milwaukee 3, Wisconsin.

MEDICAL CONTINUATION COURSES AT UNIVERSITY OF MINNESOTA

Medical continuation courses to be presented at the Center for Continuation Study, University of Minnesota, are as follow:

November 20–22: Physical Medicine for Specialists.
January 5–7: Otolaryngology for General Physicians.
January 15–17: Newer Drugs in General Practice.
January 22–24: Surgery for Surgeons.
February 23–25: Cardiovascular Diseases for General Physicians.

For further information concerning the above courses, write to the Director, Department of Continuation Medical Education, 1342 Mayo Memorial, University of Minnesota, Minneapolis 14, Minnesota.

A METHOD FOR THE CYTOLOGIC DETECTION OF TUMOR CELLS IN WHOLE BLOOD

By Richard A. Malmgren, John C. Pruitt, Pasco R. Del Vecchio, and John F. Potter, Pathologic Anatomy Branch, Field Investigations and Demonstrations Branch, and Surgery Branch, National Cancer Institute, Bethesda, Maryland.

J. Nat. Cancer Inst. 20:1203–1213, 1958

Summary: A procedure is described using streptolysin-O and a Millipore filter for preparing 20 cc. of whole blood for the cytologic detection of cancer cells. By this technique the morphology and apparent viability of the cancer cells studied are preserved and the loss of tumor cells is minimized. Erythrocytes and most of the polymorphonuclear leukocytes are destroyed, leaving tumor cells and lymphocytes on an easily screenable slide.

Addendum: Since this paper was submitted for publication, one of the authors (J. C. P.) found that centrifugation of the hemolized specimens in the presence of PVP (Plasdone C from the Antara Chemicals Division of General Analine and Film Co. of New York) with resuspension of the pellet in 0.85 per cent saline may in some instances facilitate filtration and result in somewhat lessened polymorphonuclear debris.

The PVP is added to the blood after streptolysin "O" hemolysis to a final concentration of 0.7 per cent. The specimen is then centrifuged at 225 X g for 15 minutes and the supernatant is pipetted off and discarded. The pellet is resuspended in 0.85 per cent saline and filtered in the usual manner.

A.M.A. CLINICAL MEETING AT MINNEAPOLIS DECEMBER 2–5

The twelfth A.M.A. Clinical Meeting in Minneapolis will feature a related, balanced program of lectures and clinical conferences. Attention will be focused upon the diseases and conditions most frequently met by the General Practitioner.

Registration will begin at 8:30 a.m., Tuesday, December 2. The meeting will close each evening at 5:30 p.m., and Friday, December 5, at noon. Major emphasis will be on Obstetrics, Fractures, Heart Disease, and Psychiatry. Other topics will be: Arthritis, Dermatology, Gastrointestinal Diseases, Neurology, Gynecology, Pediatrics, Pulmonary Diseases, and Surgery.

An important part of the meeting will be the Scientific Exhibits, which provide an opportunity to see at first hand the new techniques and treatments. The latest in efficient equipment for the General Practitioner will be shown by America's leading firms in the Technical Exhibits. The exhibits will be in Minneapolis Auditorium.

The scientific portion of the program will be held in Minneapolis Auditorium, while the House of Delegates, the A.M.A. policy-making body, will meet at the Leamington Hotel, headquarters for the meeting.

OFFERS FILM BROCHURES FOR SHOWING TO MEDICAL GROUPS

In expanding its film library, Eaton Laboratories has issued a package of six handsome brochures containing illustrations in color and abstracts of six films. Each film is 16 mm., with sound and color, and requires 20 minutes for showing. Five of the films relate to the use of Furacin, a topical antibacterial, and one to the use of Furadantin, for treating urinary tract infections. The titles are as follows:

Surgical Repair of Facial Lacerations
Skin Grafting of Extensive Burns
The Open Method of Burn Therapy
Complete Vaginal Repair—A Simplified Approach
Excision and Split Skin Grafting
Urinary Tract Infections—Their Treatment with Furadantin

The films are available for showing to medical groups on request to Eaton Laboratories, Norwich, N.Y.

"Something Beyond Prevention"—Mental Health in Public Health

As It Looks to Your State Board of Health

THE differences between mental health and mental illness are beginning to emerge with increasing clarity. Such clarification is of great importance both to insure better help to the mentally ill as well as to realize the untold possibilities of mental health for all people.

One authority has recently written that while the mental health movement began as a public concern for the mentally ill there is already a marked change and "as we move into the next half-century there will be much more explicit and more widespread concern for something beyond the cure of those who are mentally ill and something beyond the mere absence of pathological symptoms, something beyond prevention." [1]

According to Korner, "mental health as a workable social and scientific goal can emerge only after it has been clearly separated from the problem of mental illness." There are large numbers of people under the stress and strain of modern everyday living who, although potentially healthy, suffer emotional injury some of the time and in some degree. They are characterized by a "ceaseless struggle for restitution, for adjustment and recovery." [2] They need and can use—without too much dependence—guidance and aids which do not aim to treat pathology, but rather to enable the individual himself to use more effectively his own good potential.

Physicians, nurses, and other health personnel have unusual opportunities to promote and sustain mental health in the population-at-large. Parents, teachers, clergymen, and others can help tremendously, too. All of these have access to the widest possible cross section of the population, rather than just to special or atypical persons or groups. And this broad access is continuous throughout the life span, not limited to special occasions. The potential effectiveness of the support and guidance they can all provide is dependent on several basic conditions:

1. Valid understanding of the normal efforts of most people to adjust and to recover from the inevitable pains and injuries of living and growing.
2. Adequate knowledge of, and constructive attitudes toward, the same struggles in themselves.
3. Ability to help without unduly interfering with other people's lives or reducing their capacity to achieve independent solutions.
4. Knowledge of the basic principles of cause and effect in the emotional aspects of everyday living.
5. Ability to join effectively with parents, teachers, and others in understanding and efforts in behalf of those who need help to maintain health.

A public health program is concerned with strengthening all people in their independent efforts to live longer and more satisfactory lives. Diagnosis and cure of illness will be carefully distinguished from promotion and maintenance of health. Treating illness will be reserved to the various appropriate practitioners. Education—as it deals not only with factual information but also with feelings, attitudes, and motivation—will obviously be the main channel of public health programs. Children will be the chief focus. This mental health program of the future will not be separated from physical health, and insights and skills will be sought not only from specialists in pathology but also from such experts as parents, teachers, and clergy.

For over 15 years the Wisconsin State Board of Health has been developing a program of this health-building pattern. Through a continuation and elaboration of the teamwork with many lay and professional groups that has been evolving through the years it is hoped one day to gain for many persons that "something beyond prevention." Only a beginning has been made through these years of pioneering. Further

exploration, increased staff and research will be needed to make the best practical use of what has already been achieved in order to reach the important and challenging objectives.—A. B. ABRAMOVITZ, *Director, Division of Child Guidance, Wisconsin State Board of Health.*

REFERENCES

1. Sanford, Fillmore H.: Communication in American Psychologist, Feb., 1958.
2. Korner, Ija M.: Mental health versus mental illness, Mental Hygiene, July, 1958.
3. Blatz, William E.: Curing and preventing, University of Toronto, Bull. Instit. Child Study, June, 1957.

COMMON HOUSE PLANT FOUND TO CAUSE DERMATITIS

Some species of the popular house plant philodendron have been found to cause a skin eruption similar to that produced by poison oak.

Writing in the September Archives of Dermatology, published by the American Medical Association, two Los Angeles doctors said contact with philodendron leaves produces red blotches and streaks of tiny blisters. They usually occur on the hands and forearms, although they may occur other places.

The number of cases of dermatitis resulting from contact with philodendron is probably greater than generally thought, they said, especially since philodendrons are increasing in popularity as house plants.

The doctors have seen at least 12 cases of philodendron-caused dermatitis in the last few years. The medical literature mentions other cases.

There are approximately 100 species of the genus. The most popular as a house plant is Philodendron cordatum, a vine with small, heart-shaped, glossy leaves. Another is Philodendron selloum, which has large divided leaves and grows in a mound. The genus belongs to a family different from that to which the poison oak and poison ivy plants belong, although the skin eruptions produced by the plants look alike.

The skin eruptions generally clear after the exposure to the plants is ended.

Authors of the article are Drs. Samuel Ayres, Jr. and Samuel Ayres III.

VARIATION IN INCIDENCE OF AND MORTALITY FROM STOMACH CANCER WITH PARTICULAR REFERENCE TO THE UNITED STATES

WILLIAM HAENSZEL, *Biometry Branch National Cancer Institute, Bethesda, Maryland.*

J. Nat. Cancer Inst. 21:213–262, 1958

Summary: Available evidence on the variation in stomach-cancer incidence and mortality with respect to time trends, age, sex, race, country, geographic latitude, nativity, socioeconomic class, and urban-rural residence is reviewed. In the search for exogenuous factors that might influence the distribution of stomach-cancer cases, dietary effects appear to be the most obvious possibilities. The use of retrospective studies of cancer patients and matched controls to explore associations between stomach cancer and items of diet is discussed. Also included is a summary of variations in per capita consumption of several food items among population groups within the United States supplemented by observations for some countries with high stomach-cancer rates, which may be useful in providing leads for controlled, retrospective studies.

Single copies of the entire issue may be purchased from the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C. Price per copy $2.00.

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TRANSACTIONS OF THE 1958 REGULAR SESSION, HOUSE OF DELEGATES, STATE MEDICAL SOCIETY OF WISCONSIN

FIRST SESSION

Monday, May 5, 1958

The 1958 regular session of the House of Delegates of the State Medical Society of Wisconsin, held at the Schroeder Hotel, Milwaukee, Wisconsin, convened at 7:30 p.m., Dr. W. B. Hildebrand, Menasha, speaker, presiding.

REPORT OF COMMITTEE ON CREDENTIALS

The Committee on Credentials was composed of Drs. R. S. Hirsch, Viroqua, Chairman; Marvin Wright, Rhinelander; and L. W. Schrank, Waupun.

The Committee on Credentials verified the registration of 43 delegates and 13 alternate delegates entitled to vote at the first session of the House of Delegates. In addition, 8 alternate delegates, 3 councilors and 2 officers registered their attendance.

The Credentials Committee also reported that the following members had been duly appointed to act as delegates for county medical societies in place of the regular delegates or alternates who were unable to attend: Dr. W. A. Gramowski, Stevens Point, for the Portage County Medical Society; Dr. J. J. Rouse, Reedsburg, for the Sauk County Medical Society.

On motion of Doctor Hirsch, severally seconded, carried, the attendance roll of delegates, alternate delegates and specially appointed delegates totaling 56 was accepted as the official roll of this session of the House to stand for the entire session.

EXCERPTS FROM ADDRESS OF THE SPEAKER

Speaker **W. B. Hildebrand:** On this, the 117th annual meeting of the State Medical Society of Wisconsin, your Speaker welcomes you who have been chosen to represent your contingent societies and sections.

I think it might be interesting for all of us to see how many delegates are assuming their responsibilities for the first time. (The speaker then requested all first-year delegates to stand.)

Gentlemen, we wish to extend to you our hearty congratulations. We hope you will feel no reticence in the execution of your new duties. As the newest members of the House of Delegates you will be expected to represent your constituents well. We are glad that you are here.

And now, may we have all second-year delegates rise? Thank you. Gentlemen, we look to you, who have been through these treacherous paths once before, to guide and assist us when the going gets rough. From you much is expected and much will be asked.

Will those who have served in this House more than two years please stand? Thank you. Gentlemen, our hats are off to you. You need no instructions.

The Constitution of our parent organization, the American Medical Association, includes a clause that limits the opening remarks of the Speaker of the House of Delegates to "matters of conduct and procedure of the House".

Although the Constitution of the State Medical Society of Wisconsin stipulates no such limitation, it is a good idea. In fact, the term "Speaker" is probably a misnomer, as the real job of the Speaker is to speak as little as possible and to keep the peace between those who are in fact speakers—the members of this House. This, your Vice Speaker and I solemnly pledge to do.

Democratic government is based absolutely upon the principle of majority rule. However, majority rule requires that the minority abide by the will of the majority. The willingness of the minority to abide by the will of the majority is in turn based upon the willingness of the majority to permit the minority to have their say before final action is taken. In ancient Greece the cry of Themistocles to Euripides was, "Strike, but hear me!"

As has been said so frequently, the chief purpose of parliamentary procedure is to protect the rights of the minority. The majority can usually take care of itself. In a government controlled by public opinion, which we call a democracy, accepted rules of parliamentary procedure are not only of the highest importance—they are the foundation of freedom in every meeting, large or small, throughout our nation.

Your Vice Speaker and I shall not disdain to use mechanical aids to guide us. The Speaker of the House of Representatives of the United States has two parliamentary assistants to aid him in addition to the regular Clerk of the House. Those of you who have been privileged to watch the House of Representatives in action will recall that there is a parliamentary clerk on the Speaker's left who is a timekeeper and who keeps a check on the time allotted to each member who speaks, and identifies quickly congressmen who arise to speak.

The parliamentary clerk on the Speaker's right is called the Parliamentarian, and it is his duty to check up on all fine points of procedure that arise. He likewise helps to identify new members of Congress when they arise to speak. We feel as privileged as the Speaker of the House of Representatives to employ any aid that will enable us to smoothly conduct the business of this House of Delegates.

I should like to say a few words about our reference committees. It is the duty of the Speaker to select the chairmen and the members of these reference committees; and for these appointments the Chair takes full responsibility. You will note that the members of the reference committees are largely

delegates of experience. Wide geographical distribution has been sought on each committee. Men with special experience and knowledge have been asked to serve where their skills will be of most value. Some delegates with special knowledge of some of our problems have not been asked to serve, believing that they will want to be left free to present testimony before the committees considering the problems of their special interests. I regret that few delegates serving their first terms have been asked to serve on these committees because their qualifications have not been known to the Speaker.

May I at this time welcome the press to the meetings of the House of Delegates. We are glad indeed to have you with us here.

Each and every delegate has a responsibility, first of all, to the State Medical Society of Wisconsin; second, to his constituent society or section; third, to himself and to his fellow delegates. Let us be mature delegates. Let us so phrase our remarks that they would reflect only credit to the State Medical Society of Wisconsin and to all of medicine if they were printed verbatim in tomorrow's papers.

I emphasize this point with all the sincerity of which I am capable. Off-the-cuff, unthinking remarks on trivialities and personalities can do great harm. I assure you that I shall vigorously prosecute the theory that anyone in this House who indulges in personalities will be classified as being out of order, and his remarks will be stricken from the record.

Of course, this House may always resort to executive session with expulsion of guests. This is a procedure of doubtful value, however, always stimulating magnified interests in what went on behind the closed doors. Let us hope that there will be no necessity or request for closing these proceedings to our guests. I think if we assume the philosophy of the colored preacher who, every time he talked to his congregation, uttered a little prayer that went something like this, "Lord, fill my mouth with worthwhile stuff, and nudge me when I have said enough", we can't go far wrong in our deliberations.

Because of the fact that an attitude of restraint and a feeling of responsibility represents the highest essence of a delegate's efficiency, and because of the fact that highly controversial issues will face this House during the present session, I am taking the liberty of repeating a portion of my remarks made last year to the 1957 House of Delegates. These are excerpts from the oratory of Benjamin Franklin, and are his words that he spoke in the last Constitutional Convention when the final vote was to be taken as to whether or not the Constitution of the United States should be accepted or rejected:

"I confess that there are several parts of this Constitution of which I do not at present approve, but I am not sure that I shall ever approve them; for, having lived long, I have experienced many instances of being obliged by better information or fuller consideration to change opinions even on important subjects which I once thought right but found to be otherwise.

"It is therefore that the older I grow, the more apt I am to doubt my own judgment and to pay attention to the judgment of others. Most men indeed, as well as most sects in religion, think themselves in possession of all truths; but though many private persons think almost as highly of their infallibility as of that of their sect, few express it so naturally as a certain French lady who, in a dispute with her sister, said, 'I don't know how it happened, sister, but I meet with nobody but myself that's always in the right.'

"In these sentiments, sir, I agree to this Constitution, with all its faults, if they are such, because I think a general government necessary for us, and there is no form of government but that may be a blessing to the people if well administered; and I believe further that this is likely to be well administered for a course of years, and can only end in despotism as other forms have done before when the people had become so corrupt as to need despotic government, being incapable of any other.

"I doubt, too, whether any other Convention we can obtain may be able to make a better Constitution; for, when you assemble a number of men who have the advantage of their joint wisdom, you inevitably assemble with these men all their prejudices, their passions, their errors of opinions, their local interests, and their selfish views. From such an assembly can a perfect production be expected? It therefore astonishes me, sir, to find this system approaching so near to perfection as it does.

"Thus, I consent to this Constitution because I expect no better and because I am not sure that it is not the best. On the whole, sir, I cannot help expressing a wish that every member of this Convention who may have still within him objections to it, would with me on this occasion doubt a little of his own infallibility and, to make manifest our unanimity, put his name to this instrument."

This sums it all up much better than anything else that could be said. Let us now consider the business at hand.

ANNOUNCEMENT OF REFERENCE COMMITTEE APPOINTMENTS

Speaker Hildebrand announced the following appointments to reference committees:

Reference Committee on Reports of Officers: Drs. R. S. Gearhart, Madison, Chairman; C. J. Picard, Superior; Gordon Schulz, Union Grove; L. L. Olson, Darlington; and Gorton Ritchie, Milwaukee.

Reference Committee on Reports of Standing Committees: Drs. G. W. Carlson, Appleton, Chairman; J. P. McCann, La Crosse; H. M. Templeton, Barron; A. J. Baumann, Milwaukee; and E. W. Humke, Chilton.

Reference Committee on Resolutions and Amendments to the Constitution and Bylaws. Drs. E. D.

Sorenson, Elkhorn, Chairman; Donald M. Willson, Milwaukee; H. A. Aageson, Oconto; P. H. Gutzler, River Falls; and R. W. Mason, Marshfield.

MINUTES OF THE 1957 SESSION APPROVED

On motion of Dr. L. O. Simenstad, Osceola, seconded by Dr. C. J. Picard, Superior, carried, minutes of the 1957 regular session of the House of Delegates, as printed in the September, 1957, issue of THE WISCONSIN MEDICAL JOURNAL, were approved.

STANDING RULES ADOPTED

On motion of Dr. D. M. Willson, Milwaukee, seconded by Dr. A. J. Sanfelippo, Milwaukee, carried, the following standing rules were adopted for this session of the House:

1. Without permission of the House, reports of officers be limited to twenty minutes.
2. Without permission of the House, supplementary reports of committee chairmen or members be limited to five minutes.
3. Rule 7, Roberts' Rules of Order (1915 Ed. p. 39) be modified by the provision that no member can speak longer than five minutes at a time in debate without permission of the House.
4. The Committee on Nominations shall remain in open session for one hour to hear any delegate or alternate (or other member of the Society) who may have suggestions, after which it may proceed in closed session.
5. Roll calls:
   a. An alternate delegate is alternate for a specific regular delegate and cannot serve as a "roving" alternate delegate.
   b. There is no provision recognizing bloc voting by a county society. On roll call, individual delegates or alternate delegates or specially appointed delegates will be specifically polled as to their vote.
   c. If a delegate registers but is absent for some portion of a session, his alternate delegate cannot vote. Once the delegate registers for one of the three sessions, he is the accredited representative of the county society for the duration of that session.
   d. If an alternate delegate first registers and is recorded on the report of the Credentials Committee, and some time during the course of the session the regular delegate appears, it is the alternate delegate who is entitled to vote.
   e. At the 1949 session, the House approved the motion that in order to facilitate contested elections in the future, the system employed by the American Medical Association be utilized wherein the roll call of registered delegates is called from the Speaker's rostrum, and as the name is called, the delegate or alternate comes up and deposits his ballot, so that there can be an accurate count against registration.
6. Delegates and alternates will sign registration slips at the time they are admitted to each session of the House. Their names will be checked against a list of authorized delegates and alternates previously submitted by the county societies to the State headquarters. If an uncertified delegate wishes to be admitted, he will be referred to the Credentials Committee for its recommendation as to whether he should be admitted.
7. The registration of those in attendance at the House of Delegates, other than as voting delegates, should be handled at a separate registration table.
8. The Credentials Committee should be seated at the registration table to handle any problem that may arise, and in particular, the matter of seating an alternate at a session when the delegate himself cannot be present.

REPORTS OF OFFICERS

The Handbook for Delegates under the title, "Delegates Report" and which was reprinted in full in the October, 1958, issue of THE WISCONSIN MEDICAL JOURNAL, contained the reports of the Council and of the Secretary.

SUPPLEMENTARY REPORT OF THE COUNCIL

At the request of Dr. R. G. Arveson, Frederic, Chairman of the Council, Secretary Crownhart read the supplementary report of the Council:

Secretary Crownhart: Mr. Speaker, the Council received a report from the Committee on Public Policy indicating that substantial progress is being made toward the implementation of the request of the House in 1957 that county public policy committees be reactivated.

THE WISCONSIN MEDICAL JOURNAL is undergoing thorough review as to policy and procedures, largely as a result of a readership survey. While the survey indicates basic interest in scientific matters, there is also genuine interest in expansion of medicolegal and socio-economic subjects.

Support of the American Medical Education Foundation was discussed at length, and the Council recommended the establishment of a special committee on AMEF within the structure of the Society's Charitable, Educational and Scientific Foundation. A representative of AMEF has been invited to appear before this House of Delegates at its Tuesday evening session to explain the needs of the nation's medical schools and methods by which physicians can lend their support.

A portion of the Council meeting was devoted to a joint session with the Commission on Medical Care Plans. Approval was given to the extension of Wisconsin Physicians Service coverage into the area of dental benefits for certain types of oral surgery necessitated by illness or accidental injury. These benefits will be provided on a reasonable charge basis within established maximums. The program will be administered in cooperation with a special advisory committee from the Wisconsin State Dental Society.

The Council rescinded a requirement established in 1951 that members of the Commission on Medical

Care Plans be participating physicians in Society-sponsored or operated programs. While participation remains a basic necessity to those plans which involve full payment within defined income groups, participation is not required in the special service contract. The Council feels that representation of non-participating physicians on the Commission will improve its abilities to serve the profession and the public.

The Council is submitting to the House two resolutions filed with the Secretary after the date specified in the Bylaws. The Winnebago County Medical Society Resolution No. 16, concerning Forand and similar bills, and the Manitowoc County Medical Society Resolution No. 15, concerning Asiatic flu vaccine, have been distributed to the House, and the Speaker will make the appropriate referral.

A resolution from the Waupaca County Medical Society filed after the deadline, and concerning the activities of State mobile x-ray units, has been referred to the Commission on State Departments for thorough consideration to the matter by its Division on Chest Diseases and subsequent report to the House of Delegates.

Support in principle was extended to a proposed treatment center for emotionally disturbed children on the basis that:

1. Initial planning provide for a capacity of 25–30 beds, to be expanded later as experience and staffing permit.
2. The center should preferably be located as close as possible to the University of Wisconsin Medical School and Wisconsin Diagnostic Center.
3. The center should be closely allied to the medical school for teaching and research purposes, and planning should provide for a close interrelationship between the State Department of Public Welfare and the Medical School.
4. Admissions to this treatment center should be permitted by referral from private and other sources as well as through routine commitment procedures.

The Council emphasized the necessity for establishing this center with medical direction and with a health care outlook rather than the custodial aspects of treatment.

The recommendations of the Commission on State Departments with regard to safe transportation were approved by the Council, as outlined on page 66 of the Handbook. The Council urges county societies to give special consideration to the implementation of first-aid training for policemen and firemen and to the safe operation of ambulances on public highways.

The Council recommends to the House that Chapter III, Section 9 of the Bylaws be amended to provide that resolutions to be offered be submitted and filed with the Secretary's office not later than thirty days before the first session of the House. The present requirement of twenty days before the first session does not permit ample time to reproduce and distribute resolutions or to acquire and disseminate information and background material that might be required for their proper consideration.

In addition to this formal report, the Council has instructed me to particularly direct your attention to the report on your table, bound in red, on Medicare and Veterans Medical Service Agency.

In the few brief moments at my disposal I cannot bring to you all the implications of encountering federal medicine in the private patient care of individuals. Suffice it to say that this legislation came about to release the damaging effect on the civilian population of drafting physicians only to have them assigned primarily to civilian duty.

It was the position of the American Medical Association that the Doctors Draft Act should be abandoned and that the care of the civilian, where possible and where proper, should be returned to the civilian physician and to civilian facilities.

That law became effective on December 7, 1956. It was passed June 6, 1956. The Army was assigned the executive position of contracting with physicians through medical societies for the rendition of this care. The State Medical Society of Wisconsin took a very active part in promoting the type of contract that it felt was most beneficial for patient and physician alike.

A contract was negotiated in December which brought into Wisconsin one of the highest fee schedules in the nation, on the concept that, by and large, under such a program Medicare would reimburse physicians for their normal, usual and customary charge subject to the maximum control of an unpublished schedule.

In some respects this was achieved and in other respects it was not; but, by and large, that was the accomplishment sought and that was the accomplishment achieved.

We went into the operations of the program in December a year ago—December 1956—and here is an accounting, statistical and otherwise, as to the activity of that program. These two or three points I should like to emphasize to you!

First, the Council wishes you would read in the delegates' Handbook my report with reference to the segmentation of surgical fees. It is in the Commission report and is treated elsewhere in this report, where we encountered the government effort to divide surgical fees under the Medicare program into alleged component parts and, on a fixed percentage basis, to reimburse when a total service was not rendered.

We encountered also in those negotiations a demand by the federal government that Wisconsin, and presumably other states subsequently, justify some of its position as being within the principles of medical ethics of the American Medical Association. We told General Robinson that while we conceded to the Army high administrative and technical abilities, we did not concede to the Army the authority to determine principles of medical ethics to be applied within a governmental contract, and that while we were willing to justify our position on one of these points, we felt that concept was entirely foreign to

the federal government in its administration of any Medicare program.

The report speaks pretty substantially for itself, but it should not be considered as a report merely to be glanced at. It is precedent-making. Texas has pulled out of the program. Rhode Island does not participate. Ohio does not participate. Our decision to participate has been on the basis that taking a walk won't give us the opportunity to represent the medical profession.

Mr. Speaker, in addition to that report may I report as a supplementary necrology report the following deaths:

E. N. Brown, M.D., Arena
A. M. Ford, M.D., Roberts
G. C. Ruhland, M.D., Washington, D.C.
E. J. Schneller, M.D., Racine

It is in order for the House to arise at this point.

(The supplementary report of the Council was referred to the Reference Committee on Resolutions except for those portions of the report dealing with the treatment center for emotionally disturbed children and the recommendations of the Commission on State Departments with regard to safe transportation which were referred to the Reference Committee on Reports of Officers and Resolution No. 15 from Manitowoc County Medical Society concerning Asian flu vaccine which was referred to the Reference Committee on Standing Committees.)

EXCERPTS FROM THE REPORT OF THE PRESIDENT

President Harry E. Kasten: Those of you who read my Christmas Message to you this past Christmas will better understand when I tell you that my address to you this evening was motivated by the self-same triad of obligations; first, duty to God; second, duty to country; third, duty to the profession of medicine and the high principles for which it stands.

"A tough and unyielding barrier has been the pride in profession of a limited group who have made independence of government in their economic activities a political religion reminiscent of that of our Victorian grandfathers."

Professor J. Douglas Brown, in an article published in a recent issue of the BULLETIN OF THE INTERNATIONAL SOCIAL SECURITY ASSOCIATION, evidently directs this statement as a castigation and indictment of the medical profession.

Without question, independence of governmental interference in the affairs of medical practice in America continues to be a basic philosophy for the average physician. Warnings of the threat of nationalized medicine as a part of the plan to cover all the people under national social security has been so oft repeated as to become threadbare.

But let me say to those of you who are so minded that the Lord's Prayer has been repeated by believers in Christianity for nearly 2,000 years. Now, nearly thirty centuries later, it continues to be the supreme prayer in all Christendom.

It is my own firm conviction that the second prayer of the doctor should be that this nation be free from alien ideologies, and that our honored profession be spared from the blight of tyrannical governmental intervention and control.

Far more important than what may happen to American medicine is what lies ahead for the nation.

J. Edgar Hoover, in his forthcoming book, "MASTERS OF DECEIT", will say that the blueprint of a Soviet America has already been drawn.

Nikita Khrushchev, in a nation-wide television interview in June 1957, confidently declared, "I can prophesy that your grandchildren will live under socialism, and please do not be afraid of that. Your grandchildren will not understand how their grandparents did not understand the progressive nature of a socialistic society."

Many Americans will say that Khrushchev is bluffing. Was he bluffing when he sent up space satellites? Only American smugness underestimates the forces and design of world communism.

Let us endeavor to place American medicine in its proper niche in the jigsaw puzzle of national and international struggles for influence of the human mind and well-being.

The American Medical Association was founded in Philadelphia, May 5, 1847. The first fifty years were those of any young organization. It was a heterogeneous admixture of discordant elements whose behavior was one of confusion and strife.

The year 1900 marked a major turning point in the life of the American Medical Association. Now came the transition from adolescence to adulthood.

The fifty-eight years since 1900 may logically be divided into two phases—first, the Rise of Medicine to a place of supremacy in the socio-politico-economic fabric of this nation; second, Medical Readjustment to Changing Sociological Concepts.

PHASE ONE: The Rise of Medical Prestige

The rise of medical prestige came on rapidly, in part due to better public relations, in part to improving skills and practices of modern scientific medicine.

Early public resentment rapidly turned to admiration for our efforts in protecting the people from nostrums, quacks, patent medicine, bogus medical schools, unprincipled medical periodicals, and commercially tainted manufacturers.

Dr. Harvey S. Wiley waged an incessant campaign for pure food and drugs, which resulted in the passage by Congress of the Pure Food and Drug Act. It is to the credit of American medicine that the doctors of this nation staunchly and consistently supported his one-man crusade.

However, I think it is an incontrovertible fact that two achievements of organized medicine did more than any other to enhance the prestige of American physicians.

One was the fabulous advance of the art and science of medical practice in America.

The second was the development by physicians of their own medical and surgical insurance programs, commonly known as Blue Shield or "The Doctor's Plan". Both achievements are deserving of a few words of special comment.

I predict that medical historians will say that the advance in medical science in the first fifty years of the present 20th Century will surpass those made in the entire preceding fifty centuries.

New drugs, improved diagnostic facilities, better hospitals, better nursing care, and an amazing advance in therapeutic medical and surgical skills have combined to make the United States the world medical center.

As to economics, the important date was the 1934 Cleveland Session of the American Medical Association. At that meeting the Bureau of Medical Economics submitted a ten-point program as a prerequisite for experiences in administering medical care through health insurance. This was tantamount to AMA sanction of the general theory of prepaid health insurance to be conducted under the auspices of doctors. This may be considered the early labor pains attendant on the anticipated birth of voluntary prepaid medical insurance plans.

Three years later, in part as the result of incessant agitation of the proponents of compulsory national sickness insurance, the Board of Trustees of the AMA requested physicians to develop and put into practice a comprehensive system of medical care for all the people. In this manner Blue Shield was born. Its remarkable success in most of the forty-eight states of the Union brought substantial prestige to the medical profession through evidence of the physicians' leadership in an important socio-economic problem.

PHASE TWO: The Medical Readjustment to Changing Sociological Concepts

It would be a fatal mistake to assume the rise of medical prestige and the period of readjustment during the first half of the 20th Century had a chronological sequence as to time.

In fact, the events and factors that enhanced medical prestige in America, and those which were detrimental to it, constituted an interplay of cross currents operating simultaneously and discernible only to the most searching scrutiny.

The chief cross-current which had an adverse effect on American medicine was due to the origin and development of a relatively new concept of social behavior known as socialism. In order to better understand the powerful impact of this philosophy on the American doctor, it becomes necessary to explore a bit of British history.

The term "socialism" was originally applied to a number of vague theories for the reconstruction of the hated capitalistic system of society. In 1884 the Fabian Society was organized in England. It was the forerunner of what was known as Fabian socialism in England. It had among its membership Sir Ramsey MacDonald, who rose to the Premiership of England, and George Bernard Shaw, the noted dramatist, playwright and literary critic. Through gradual acquisition of political influence and power it succeeded in making England a welfare state.

In 1911 Great Britian enacted its first compulsory health insurance law. All things medical came into the orbit of control by the state, including the doctors. Flushed by their successes in socializing the economy of England, the international social planners cast longing glances at the richest prize of all—the United States of America.

Amerca's conversion to the Fabian ideology was essential to the over-all purpose of world socialism.

When one considers the fact that much of the thinking of the Eastern seacoast has been and still is more alien than American, it becomes almost crystal clear that conversion of the philosophy of individual enterprise of the nation to the philosophy of the welfare state should not have been too difficult. In fact, its progress was more rapid than the Fabian socialists had dared to dream. People everywhere are endeavoring to get into the act to drum up the purported virtues of the new so-called American emancipation.

Newspaper editors, politicians, columnists, church men and even doctors are elbowing their way in their eagerness to get on the bandwagon. Social security has become a catchword, a slogan and a fetish among a large segment of the American people. One by one, organized groups of our society have fallen under the seductive spell of security literally "from the cradle to the grave", with but one understanding exception—a "limited group who have made independence of government in their economic activities a political religion"—the doctors of America organized as the American Medical Association.

The American proponents of the welfare state and particularly socialized medicine now trained their guns on the "tough and unyielding barrier".

They had quite successfully indoctrinated a large portion of the civilian population. What remained was to "cut down to size", to intimidate, to discredit and humiliate the remaining barrier—the doctors of this nation—operating under the banner of the American Medical Association.

First came the direct assault by attempts to adopt compulsory health insurance, the most noted of which was the Wagner–Murray–Dingell bill. Those attempts failed because of the rugged opposition of medicine.

Then came intimidation. In 1940 the AMA was accused of violation of the Sherman Antitrust Act. After a lengthy trial the court found the AMA and the Medical Society of the District of Columbia guilty of restraint of trade.

The court said in part, "We think enough has been stated to demonstrate that the common law governing the restraint of trade has not been confined, as the defendants insist, to the field of com-

mercial activity ordinarily as trade, but embraces as well the field of the medical profession."

The implication seems clear—doctors are tradesmen—doctors who by longstanding reputation are inept businessmen!

In the next fifteen years there were repeated attacks on American medicine through the courts and through the legislature. These frontal assaults were met with failure. The proponents of socialized medicine then turned to the original Fabian teachings of gaining the desired end by skillfully concealing the main objective behind diversionary skirmishes and by piecemeal conquest. In modern political parlance this is known as "getting in through the back door".

"Nothing short of a national health service holds promise of meeting the total problem" of medical care for all Americans. So says Eveline M. Burns, President of the National Conference on Social Welfare. But she adds quickly, "I am enough of a realist to recognize that this will not be achieved in my lifetime and that we in America will approach this goal piecemeal. . ."

The planned-economy advocates hoped by this means to condition the American public so thoroughly to the philosophy of social security that the final coup—socialization of American medicine—the last barrier to complete socialization of the entire American economy—would fall like a ripe plum into the victory basket of the social planners.

Some idea of the erosion of private medicine by government can be gained from the fact that we have now eligible for tax-paid medical care 23 million veterans, 5 million military personnel and dependents, over 5 million public assistance recipients, 300,000 beneficiaries of public health service, 370,000 Indians and Eskimos, and 4 million federal employees (injuries only).

If the Forand bill which would provide hospitalization and surgical benefits to all old-age and survivors insurance beneficiaries (and a recent bill would provide medical care as well) is passed, it will add another 12 to 13 million persons as medical wards of the federal government. Thus, approximately 47 million people will have their medical needs supplied by the federal government, wholly or in part.

The record seems to show that inclusion under social security has swept the nation like a prairie fire.

A Committee on Social Security for Physicians is actively and seemingly successfully carrying on a campaign for the compulsory inclusion of doctors under social security. It would destroy the "limited group who have made independence of government in their economic activities a political religion" by forcing it to raise the white flag of surrender, thus removing the last effective barrier to socialized medicine in America.

Now, finally, permit me to close my final message to this House of Delegates with a few thoughts on Wisconsin medicine gleaned from my President's page, published in the April issue of THE WISCONSIN MEDICAL JOURNAL.

The State Medical Society of Wisconsin is a dynamic organization, dedicated to better and more modern medical services, all in the finest tradition of Wisconsin medicine.

A spirit of progress has been reflected during the past year in all the activities that have been carried on through cooperative efforts of all the several sectors of the Society structure. I feel that we owe a vote of gratitude to the many devoted men and women who defied time, distance and the elements in actively and diligently serving on the many and various State and county committees.

The fine work of these committees, carried on with the help and guidance of an extraordinarily capable and efficient home office staff, has accrued to making the activities of the past twelve months another jewel in the diadem of traditional Wisconsin medicine.

The record of achievement as well as the problems of Wisconsin medicine for the past year are recorded in the Delegates' Handbook. I urge you to read it carefully.

Permit me to discuss briefly again what I consider to be organized medicine's greatest problem.

In my inaugural address last year I declared that unity would be the major theme of my administration. Now, after twelve months, I am convinced that it remains our major defection.

I would like to direct your attention not to unity as such, but rather to one of the essential ingredients of this laudable quality of human behavior. As vanadium is added to iron to make the resulting product tougher and more serviceable, so must an ingredient be added to human behavior in an effort to establish a more practical and effective form of cooperative social conduct.

Like unity and loyalty, this ingredient is something intangible, yet real in the sense that the eternal verities—faith, hope and charity—are intangible but real.

Like unity and loyalty, it can never be bought. It must be earned.

It differs from the usual types of unity and loyalty, which too often are illusionary and evanescent in character, in that it is acquired in what is commonly known as "the hard way". The further difference lies in the well-known fact that when once acquired it becomes an almost ineradicable factor in the subsequent pattern of life.

What is this thing of which I speak?

The fame of the United States Marines and the French Foreign Legion is based on this particular quality of human behavior. The amazing French, to whom mankind is indebted for so much of our cultural progress, expressed it in this very significant phrase: esprit de corps.

The definition of this well-known but not always well-understood phrase is taken from Webster's New International Dictionary. "The common spirit pervading the members of a body or association. It implies sympathy, enthusiasm, devotion, and a jealous regard for the body as a whole."

I respectfully invoke your sincere and thoughtful concern for a number of badly cracked stones in the foundation of the House of Medicine to the end that, "Having done all, to stand."

REPORT OF THE PRESIDENT-ELECT

The report of the President-Elect, J. W. Fons, Milwaukee, was published in the June issue of THE WISCONSIN MEDICAL JOURNAL.

COMMITTEE APPOINTMENTS

On motion of Dr. L. O. Simenstad, Osceola, seconded by Dr. J. D. Leahy, Park Falls, carried, the following committee appointments of the President-Elect were approved:

Committee on Cancer:

Dr. J. W. Boren, Jr., Marinette
Dr. C. W. Stoops, Madison
Dr. A. H. Stahmer, Wausau
Dr. Carlton Wirthwein, Milwaukee, chairman for 1958–1959

Committee on Coordination of Medical Services:

Dr. Einar Daniels, Milwaukee
Dr. M. O. Boudry, Waupaca
Dr. J. F. Wilkinson, Oconomowoc, chairman for 1958–1959

Committee on Grievances:

Dr. E. J. Nordby, Madison
Dr. Harold J. Belson, Manitowoc
Dr. R. R. Richards, Eau Claire
Dr. E. D. Sorenson, Elkhorn, chairman for 1958–1959

Committee on Hospital Relations:

Dr. J. P. McCann, La Crosse
Dr. E. S. Olson, Racine
Dr. S. W. Hollenbeck, Milwaukee, chairman for 1958–1959

Committee on Medical Education and Hospitals:

Dr. N. M. Clausen, Madison
Dr. T. L. Squier, Milwaukee, chairman for 1958–1959

Council on Medical Service:

Dr. J. S. Devitt, Milwaukee
Dr. W. J. Fencil, Monroe
Dr. D. M. Willison, Eau Claire, chairman for 1958–1959

Committee on Public Policy:

Dr. E. T. Rechlitz, Beloit
Dr. A. A. Quisling, Madison, chairman for 1958–1959

Council on Scientific Work:

Dr. R. W. Farnsworth, Janesville
This committee to select its own chairman

REPORT OF THE TREASURER

Dr. F. L. Weston, Madison, treasurer, presented the treasurer's report, which relates only to those operations of the Society which are the direct responsibility of the treasurer.

STATE MEDICAL SOCIETY OF WISCONSIN
MADISON, WISCONSIN

To The House of Delegates:

In accordance with Section 3, Chapter 5 of the Bylaws of our Society, I submit, herewith, my annual report of the state of the Society's funds at December 31, 1957, and the operations of the Society during the year 1957.

This report relates only to those operations of the Society which are the direct responsibility of the Treasurer. Accordingly, it does not include information with respect to financial condition and operations of THE WISCONSIN MEDICAL JOURNAL, Wisconsin Physicians Service, and the Wisconsin Veterans Medical Service Agency. However, the net worth of THE WISCONSIN MEDICAL JOURNAL is included in the Society's net worth in this report. Since reserves of the prepaid plans are held by them for internal purposes, they do not represent any part of the Society's net worth. The Wisconsin Veterans Medical Service Agency, performing solely as an agent, has no excess or deficiency of income related to expense, and therefore, no net worth.

The following Exhibits and Schedule make up this report:

Exhibit A—Financial Statement at December 31, 1957

Exhibit A-1—Reconciliation of Net Worth at December 31, 1957

Exhibit B—Statement of Income and Expense Year Ended December 31, 1957

The records of the State Medical Society of Wisconsin are now being audited for the year 1957 by Donald E. Gill and Company, Certified Public Accountants.

F. L. WESTON, M.D.
Treasurer

May, 1958

STATE MEDICAL SOCIETY OF WISCONSIN
Madison, Wisconsin

FINANCIAL STATEMENT
December 31, 1957

ASSETS		
Cash on Hand and in Banks		$ 57,969.85
(Principally prepaid 1958 membership dues and other 1958 income prepaid)		
Due from Divisions and Related Organizations of the State Medical Society:		
Wisconsin Medical Journal	$ 1,831.54	
Wisconsin Physicians Service	28,230.37	
Wisconsin Veterans Medical Service Agency	$ 1,362.73	
SMS Realty Corporation	1,392.02	
Charitable, Educational and Scientific Foundation, Inc.	18,124.33	
Total		50,940.99
(Primarily advanced operating expenses)		
Other Accounts Receivable		2,344.58
Working Capital Advances:		
Wisconsin Medical Journal	$ 33,550.40	
Wisconsin Veterans Medical Service Agency	7,500.00	
Total		41,050.40
Guaranty Deposit—Northwest Airlines		425.00
Furniture and Equipment	$ 32,976.39	
Less: Accumulated Depreciation	21,424.62	
Fixed Assets Net Book Value		11,551.77
Prepaid Expenses and Deferred Charges		7,924.62
TOTAL ASSETS		$172,207.21
LIABILITIES		
Vouchers Payable	$ 17,800.52	
Dues—Suspense	140.00	
Accrued Expenses	1,101.17	
Prepaid Membership Dues	40,649.00	
Prepaid Auxiliary Dues	780.00	
Prepaid Annual Meeting Income	7,017.50	
Other Deferred Income	170.00	
TOTAL LIABILITIES		67,658.19
NET WORTH		
Surplus General Fund	$ 68,825.27	
Net Worth of Wisconsin Medical Journal	33,550.40	
Surplus Reserved for New Building	1,075.00	
Surplus Reserved for Section on Medical History	1,098.35	
TOTAL NET WORTH		$104,549.02

STATE MEDICAL SOCIETY OF WISCONSIN
Madison, Wisconsin

RECONCILIATION OF NET WORTH
Year Ended December 31, 1957

Net Worth—December 31, 1956		$ 75,046.88
Deduct: Subsequent Audit Adjustments		1,171.38
Adjusted Net Worth—December 31, 1956		$ 73,875.50
Additions:		
Excess of 1957 General Fund Income over Expenses	$ 17,906.41	
Increase in 1957 of Net Worth of Wisconsin Medical Journal	12,767.11	
Total Additions		30,673.52
Net Worth—December 31, 1957		$104,549.02

STATE MEDICAL SOCIETY OF WISCONSIN
Madison, Wisconsin

STATEMENT OF INCOME AND EXPENSE
Year Ended December 31, 1957

INCOME		
Administrative and General Income		
Membership Dues—Current Year	$199,785.20	
Membership Dues—Prior Year	1,889.50	
Total		$201,674.70
Other Income		
Annual Meeting	$ 22,096.50	
Postgraduate Clinics	7,063.34	
Section on Medical History	587.00	
Cafeteria	16,109.97	
Miscellaneous	4,624.43	
Total		50,481.24
TOTAL INCOME		$252,155.94
EXPENSES		
Accounting Services	$ 3,745.39	
Association Dues	1,030.70	
Cafeteria—Food and Supplies	12,402.77	
Conference Expense	30,223.96	
Depreciation	2,551.59	
Grants and Appropriations	10,000.00	
Insurance—General	887.71	
Insurance—Employees	2,441.24	
Legal Service	3,742.48	
Legislative Retainer	3,450.00	
Miscellaneous Expense	1,862.56	
Office Supplies and Expense	5,097.41	
Outside Services	5,643.21	
Postage and Express	6,366.66	
Printing and Forms	16,726.07	
Promotion	3,649.70	
Property Taxes—Personal Property	390.13	
Rent—Central Office	18,728.00	
Rent Other	5,536.95	
Rental—Other Equipment	411.40	
Repairs and Maintenance—Equipment	714.13	
Resource Material	1,918.49	
Retirement Plan Contributions	3,630.66	
Salaries	87,537.07	
Speakers' Honoraria	3,586.72	
Taxes—Payroll	1,784.81	
Telephone and Telegraph	2,826.03	
Travel Expense	7,048.24	
Loss on Disposal of Fixed Assets	56.86	
Total		$243,990.94
Less: Portions of above expenses charged out for services rendered to others		9,741.41
TOTAL EXPENSE		234,249.53
Excess of Income over Expense		$ 17,906.41

SUPPLEMENTARY REPORT OF THE SECRETARY

Secretary Crownhart: It is always a pleasure for me to appear before the House of Delegates in my capacity as your Secretary, for it is from within this body that I must seek administratively to coordinate the strength of medicine and the many problems that confront us in our efforts to discharge the responsibility that you assign to your principal administrators.

All the committees and all the Councilors are certainly intimately acquainted with the activities of our Society, but to me that is not enough. There must be the House of Delegates, the alternates, the presidents and secretaries of county medical societies, who carry a responsibility which it is my duty to bring to them and to enunciate for the cooperative effort that is produced in Wisconsin by the work at home, work that is superlative in legislation, in contacts with various State departments, in our relationship with the public, and in our operating activities including those of Blue Shield.

Possibly many of you know me only as the brother of George, and some of you know me for myself. None of you knows me for the son of my father or the son of my mother. My father was a very active civic leader in Wisconsin politics, and was affiliated with what in those days was not an entirely popular movement, known as Progressive Republican. I inherited his political fate and came into the position of Secretary as well as attorney at times for the Society, one which was viewed in the public eye as conservative, but I came into it in the fate of a Lafollette Republican.

My mother was a schoolteacher, a county superintendent of schools, and one very loyal and devoted to her family. I am reminded today of a story that she told me, and I am reminded of it because of the fact that on April 11 or 12 there was delivered to my desk a communication from Milwaukee which I felt impelled as Secretary to take to the road.

She told the story of the Finnish girl at the race track, highly excited as the race wore on and the horses were neck and neck. One was gradually drawing ahead. The little Finnish girl, new to the community but very loyal to her horse, said, "Look at she! Look at she! Don't tell her we can't run!"

For the past three weeks I have been running—I hope effectively.

I want to address my remarks as a supplementary report of the Secretary as much to the public of Wisconsin as to the physicians of this State.

We have been confronted in the past year with many problems of administration. Last year you will remember the great crisis before the House of Delegates was the stature of the chiropractic in Wisconsin legislation. This year it appears to be along another line.

It has become incumbent upon me as your General Manager to develop a working organization to implement Blue Shield, to provide for its own those services which are at once delegated to another organization.

Just before the House met a year ago, knowledge that some problems existed was brought to the Council, and the Council by motion directed a further meeting after the House had adjourned. At that time a detailed outline of our agency problem was presented as best and as much in detail and as factually as my staff and I could prepare it.

There was no decision made on that day, which may be marked in your memory as May 9. It is not marked in my memory as a day of decision but as a day on which further efforts were to be made to bring about a solution of an existing financial problem.

Negotiations continued from May 9 on into June, and then, nearing the termination date, on our own motion another month was added, and negotiations continued into July.

At the meeting of the Council at the end of July 1957 the state of affairs of our negotiations was reported, and at that meeting the Council expressed a vote of confidence in the Commission on Medical Care Plans and in those who had been most intimately connected with the problem of negotiations.

August 1 came, and there ended by contract the delegation that we had given to our agent. Nevertheless, hoping that some other arrangement might be made, toward the end of August Dr. Dessloch, of Prairie du Chien, Chairman of the Commission and a Councilor, and I took upon ourselves, after conference with others, to come to Milwaukee and endeavor to present the possibilities of a continued financial relationship on a more limited basis than had existed prior to July 31.

Toward the end of September apparently those negotiations were proving fruitless. We knew that by terms of the relationship, by February 1 the child would have to move into its own house, be prepared to do its own cooking, and to cut the apron strings which had so well and effectively led it to that state of maturity.

That decision, then, reached in late September, obviously impelled my staff and myself to do what we have always, I think, felt confident of being able to do, namely, run the whole of our office as well as a part of it; and we staffed and we got the secretaries and we got our IBM machinery, and I am happy to report to you now that the Blue Shield operations are totally those of the State Medical Society, and that they are in full and successful operation.

I would like to report further when I say I am addressing myself to Mr. Public. I have heard here in this House of Delegates for many years the statement ofttimes repeated—and I think always sincerely meant, sometimes forgotten in the heat of battle—that what is good for the public is good for medicine, and there cannot be something that is good for the public and harmful to medicine, and that there can't be something harmful to medicine and good for the public. It is a two-way street in which this medical fraternity has endeavored logically and soundly to serve the public of this State, and I would like to think it has served them (referring to my opening remarks) in a progressive sense as well.

This State Medical Society does not stand characterized as reactionary, selfish, parsimonious. It stands as a State Medical Society able and willing to face up to the facts, and when it sees those facts and analyzes them it uses its judgment in the public's interest.

There is grave danger, in my estimation, that insurance can be priced out of the reach of the common man. Insurance is not devised for the wealthy who can pretty much self-insure themselves. Insurance isn't devised for the sovereign branch of government which holds that the power of taxation enables it to postpay and not prepay. Insurance in the medical-surgical field and in the hospital field is intended to provide the common man with the ability to secure a protection of prepaying his hospital, medical and surgical expense and those unanticipated crises which in former years brought him to the doors of public assistance or to seeking a loan at the bank or to depending upon the beneficence of relatives who were not always so inclined.

Insurance in that concept has been administered in Wisconsin. When we think of fee schedules, we must think of their impact upon the costs to the person who is going to pay the bill. This is not to level schedules of benefits to unrealistic and basement structures, nor is it to elevate the schedules of benefits to bring to the medical profession of this State a total achievement of wealth through bureaucracy and bureaucratic effort.

Rather, indeed, it is to bring to the people a program which serves their needs and which is conceived in their interests, and in which they may have confidence, and in which they may know that the plan will progress, as indeed does the medical profession in the science of medicine.

All these efforts required studies, and there were many of them. Internal studies were made by my staff—or, if you wish, your staff—studies by myself on many, many a night and week-end. Studies were made by employed independent consultants whose standing in their fields is preeminent and whose services to us have been devoted. One of those was employed from Chicago, particularly to come to Wisconsin and establish an assured mechanism of operation, probably not perfect because nothing we ever do is perfect, but with the assurance in an anticipatory sense that we are on the road to adequate management of our program. That individual now heads the electronic system of Blue Cross and Blue Shield in Illinois, and is high in the esteem of his fellow workers in the nation.

What happens now is a matter of being permitted to devote, on my part and that of the staff, the best constructive leadership we can give you, when perhaps some of our efforts are somewhat at stake.

I plead for the opportunity to serve, not for the further opportunity of argument and debate and keeping a Mary Astor diary. I have placed on your desks, as I think I have a proper right and responsibility to do, an address by Louis H. Bauer, given just a week ago to a national meeting of Blue Cross and Blue Shield people. It should be read in its entirety.

Dr. Bauer is one of the most distinguished members of the medical profession. You all know of him. I won't recount his personal history. If you will note, on page 5 he discusses:

> "Originally Blue Shield was very small, and it started out five years after Blue Cross. Blue Shield, therefore, had very much to gain by a close relationship to Blue Cross. Because it was larger and had a greater fund of experience, Blue Cross was able to help the younger plan immeasurably. Both plans worked closely, both benefited from the sharing of talent and experience, and both grew quickly. There was a tendency in those early years, because Blue Cross was the older, more experienced partner, for Blue Cross to become the dominant half of the liaison. Now, however, the situation is changed. Blue Shield has a depth of experience it lacked before and is growing faster than Blue Cross. I believe that the two plans should now be partners on an equal footing. Neither should dominate the other."

At the bottom of the page Doctor Bauer states:

> "It is very disheartening to view the state of affairs that exists in those areas where the two organizations are more or less one in fact, even if not in theory. Because Blue Shield has been the junior partner it seems often to act hesitantly, without vigorous conviction in the course it must follow, content to be hand-led and spoon-fed by the elder Blue Cross. What is to be gained by one plan hiding in the shadow of the other? Blue Shield is no longer in swaddling clothes. It has reached adult state. Both plans are working to serve the community. They should work in harmony, yes—share those duties that will benefit both plans—but each plan should be the master of its own fate."

It has much to do and much farther to go. It will never be the largest Blue Shield in the country because its territory is too restricted. It may not even be the larger of the two Blue Shield plans in Wisconsin because it works in a more sparsely settled area and lacks the industrial concentration with which to contact.

Blue Shield of Wisconsin, like any other Blue Shield plan, so minded, can be one of the outstanding programs of the country, dedicated to the public, dedicated to the medical profession, encouraged by support and conviction and wisdom and public acclaim to keep constant with what you men in this very learned profession have to offer.

I think those days will prove themselves, given the opportunity to work in a freedom of atmosphere and with a sincerity of purpose and with an assurance of medical support.

ADDRESS OF THE PRESIDENT OF THE WOMAN'S AUXILIARY

Mrs. A. J. Baumann, Milwaukee: As President of your Auxiliary, this past year has been a busy one but a most rewarding one—rich in experiences and friendships which I shall cherish always. Outstanding has been the willing and enthusiastic cooperation of the officers, chairmen and members. These women are the salt of the earth—your wives, doctors.

Everything we do as individuals and as groups becomes public relations—and, I hope, good public relations. Almost every member serves her community in some way—blood bank, immunization programs, health drives, civil defense, safety councils, child health programs, VNA, hospital auxiliaries, PTA, scouting, church work and many others.

One county of twenty-five members recorded the hours of volunteer service and reported a total of 1,624.

Two new projects which I think should be included in public relations are, first, the cooperation of the Milwaukee County Auxiliary with Marquette Medical School on a Careers Day during Medical Education Week, and, second, Dane County assisted the wives of medical students at the University of Wisconsin in organizing an Auxiliary to SAMA, the Student American Medical Association. This is a national organization chartered two years ago.

In medical legislation I think our assistance can be of much value. We can give the time which the busy doctor does not have—and, believe me, many women are interested in legislation and are well-informed. Our Chairman has just set up a network task force of eighty women ready to go into action when the need arises.

Last year our efforts were directed toward defeating the chiropractic bills, and this year most groups have studied the Forand bill and are prepared to unite in the fight. Some time ago a representative told me that congressmen consider women the most influential lobbyists any group can have.

The No. 1 priority project this year was AMEF. Our contribution will be $3,000 plus proceeds from special convention features. These corsages and packs of this notepaper will be sold. However, most of the money was raised by social benefit functions. Racine County Auxiliary, our energetic and imaginative convention hostesses, are giving a gift to AMEF as a prize to the county with the largest percentage of registration. They also made the corsages.

Recruitment and scholarship are likewise high on our priority list. The total amount given or loaned is over $6,000 for nursing, practical nursing and allied medical careers. Auxiliary members sponsor about forty Future Nurses and allied careers clubs of several hundred high school girls. On April 5 our fourth convention of all groups was held in Madison.

Our "Operation Santa Claus" was the "something new" in mental health. Seven hundred seventy-two "forgotten people" in our five State mental hospitals received personal gifts from Auxiliary members. The forgotten people are those who have not been remembered by family or friends for two or more years. The overwhelming response to this operation was heartwarming, and the "Thank you" from recipients brought tears to many eyes. Our conscientious chairman feels well rewarded for her many hours of work, and members have asked that this become an annual mental health project.

On TODAY'S HEALTH our percentage has dropped. This is regrettable because we think it is a fine health publication. This is one phase of Auxiliary work in which every doctor could give assistance just by placing it in his office. What finer health information can you obtain for your reception room reading than TODAY'S HEALTH, published by the AMA? Of interest to all in the May issue is a comparison of medicine in Russia and the United States by Wisconsin's Dr. Gunnar Gundersen.

The National Auxiliary slogan this year has been, "Health is a Joint Endeavor". Our theme has been "Partnership"—a closer relationship between our two groups. Most counties have had at least one joint meeting, either social or with a speaker of mutual interest. Emphasis on a closer relationship was the theme of Dr. David Allman, in his President's Page in the AMA Journal of February 22, 1958. To be sure you do not miss reading this tribute to the Auxiliary, we have reprints which will be passed around later. Please read it. The reading time is only four minutes.

Your vote last year to include Auxiliary dues of $3.00 with your billing was in a sense an act of partnership. We are sincerely grateful for the sentiment and, of course, the financial aid.

There has been some confusion and misunderstanding relative to this new billing procedure. However, it seems to be developing into a smooth running system, and surely we all know that integrating people or new systems incurs some growing pains.

While we are discussing partnership, I would like to present a matter for your consideration. In October 1952 this recommendation was presented by the Reference Committee to your House of Delegates: That the President of the Woman's Auxiliary be sent notices of committee meetings in which the Auxiliary would be interested and could be of assistance in developing projects discussed. This recommendation was voted unanimous acceptance, and I would like to suggest that it be initiated.

In this busy year we have not forgotten our Wisconsin Charitable, Educational and Scientific Foundation—but we are saving that for tomorrow. Nor have we forgotten the financial needs of our State Medical History program, and I would like to take care of that right now.

Doctor Stovall, from the Woman's Auxiliary for the Medical History mural planned for the State office, I happily present these checks to you—$100 from the Rock County Auxiliary and $100 from the State Auxiliary.

Our sincerest thanks to Mr. Crownhart, office personnel, our Advisory Board, and to our much-loved Leona Chesemore for their assistance and wise counsel on Auxiliary planning and problems. And a loving "thank you" to my husband, whose cooperation and understanding have meant so much to me.

Thank you, gentlemen, for your kind attention. If you would like to know more about the Woman's Auxiliary we would be pleased to have you visit us in the Loraine Room on Wednesday or Thursday morning. May I also invite you to visit our exhibit booth in the Auditorium. This is our first experience in exhibiting, and we would appreciate your suggestions.

President-Elect Fons introduced Mrs. Gordon Schulz, Union Grove, President-Elect of the Woman's Auxiliary to the State Medical Society of Wisconsin.

REPORTS OF COUNCIL COMMITTEES

The reports of the following Council Committees were printed in the Delegate's Report which appeared in full in the October, 1958, issue of THE WISCONSIN MEDICAL JOURNAL:

Committee on Diabetes
Editorial Board
Committee on Civil Defense
Commission on Medical Care Plans
Commission on State Departments
Division on School Health
Division on Public Assistance
Division on Safe Transportation
Division on Geriatrics
Division on Visual and Hearing Defects
Division on Handicapped Children
Division on Rehabilitation
Division on Chest Diseases
Division on Maternal and Child Welfare
Division on Nervous and Mental Diseases

REPORTS OF STANDING COMMITTEES

The reports of the following standing committees were printed in the Delegate's Report which appeared in full in the October, 1958, issue of THE WISCONSIN MEDICAL JOURNAL:

Committee on Public Policy
Committee on Cancer
Committee on Hospital Relations
Council on Scientific Work
Committee on Coordination of Medical Services
Council on Medical Service

SUPPLEMENTARY REPORT OF THE COUNCIL ON SCIENTIFIC WORK

Dr. L. G. Kindschi, Monroe, chairman: I am sure you all know that the function of the Council on Scientific Work is primarily educational, dealing with those areas of postgraduate education that appeal to the entire membership of the State Society.

As such our No. 1 responsibility is the setting up and running of the annual meeting. I was rather surprised when I came here tonight to find that this is No. 117 for the Wisconsin State Medical Society. I hadn't realized that this Council had been going that long.

There have been certain problems that have arisen in setting up these meetings. I am sure you are all aware of the fact that the practice of medicine has become to some extent segmented, partly by specialties, partly by the development of the general practitioner society, the generalists. Nevertheless it is the responsibility of this Council to include all of the membership in the annual meeting.

As a result, the format has been developed and has been presented in the past few years, a format that devotes one day to the generalists' interests and the other two days to the interests of the special groups. The whole thing is coordinated. The level that we seek to attain on the first day is not essentially different from the level we seek to attain on the other two days.

The success of this format can be demonstrated by the fact that last year in the 1957 meeting we had an attendance of over 50 per cent of the membership of the State Society.

The second facet of the educational program that this Council carries on has to do with the circuit teaching program. Here again we have come into a certain amount of competition with other groups that are developing postgraduate educational programs. Nevertheless, the academic aspect of the circuit teaching program has been sufficiently appealing so that last year approximately 30 per cent of the membership of the State organization was in attendance.

During the next academic year of 1958 the circuit teaching programs have been cut to four. They will be in October, November, January and February of this particular academic year.

We are doing this a little bit differently. We are not having the prolonged programs nor the dinners this year, but we are going ahead with the general program in the afternoon and are leaving the evening meetings out of the picture.

There are always questions that arise for which the members of the Council are seeking an answer. First of all, does the clinic that is being presented reach the physicians whose geographic location limits access to regular programs?

Second, does the clinic replace or augment hospital staff programs in a smaller institution?

Third, is the subject matter of wide or limited appeal?

Fourth, is the teaching material transmitted by those who attend to a wider audience of colleagues through later daily contact?

Those are the essential questions we have to face and upon which we have to make decisions.

There are many other areas in which postgraduate training can be carried out. The other scientific programs under the Society's sponsorship have included such things as two Inhalation Therapy Institutes, presented by the Society's Charitable, Educational and Scientific Foundation. These two Institutes attracted 150 physicians.

The Prematurity Institutes, under the direction of the Society's Division on Maternal and Child Welfare, have become highly popular. More than 300 attended during the last academic year.

Such has been the major activity of the Council on Scientific Work. There is, however, under consideration even further educational procedure. The one under consideration at the moment is a pilot study of consultations to be held at individual hospitals throughout the State. This, however, is in no further state of advancement than just consideration.

I am sure you can understand many of the problems involved in setting up a program in a single hospital, asking the practitioners of the area to attend, taking their time and giving them something worth while. Nevertheless, we feel that this has tremendous possibilities, and the Council is proceeding to investigate these possibilities.

At this time I want to extend a particular word of appreciation to the staff of the State Medical Society that has been of such tremendous help in

setting up these programs, particularly Mr. Ragatz and Mr. Thayer. Without their help we would simply be swamped.

The general support of the Council has been superb, and I hope this particular program at this meeting will continue to hold up the traditions of the past.

REPORT OF THE CHARITABLE, EDUCATIONAL, AND SCIENTIFIC FOUNDATION INC. OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Secretary Crownhart reported that the Board of Trustees of the Foundation ordinarily met preceding the House of Delegates but because of conflicting events the Board would not meet until the third day of the annual meeting.

He reported, however, the recommendation of the Executive Committee of the Foundation that voluntary contributions from physicians be continued in the year 1958–1959 in the same amount as in prior years, namely $10.00. (Referred to the Reference Committee on Resolutions.)

REMARKS OF THE STATE HEALTH OFFICER

Dr. Carl N. Neupert: Again I am grateful for the privilege of bringing before you matters of concern in promoting healthier living on the basis that "What is good for the public is good for the doctor."

This year permit me to emphasize two new developments involving especially cooperation between practicing physicians and the State Board of Health in the endeavor to move forward toward reducing disabilities or their after-effects due to certain chronic diseases.

Some of our colleagues take the position that concern with prevention or the early detection or ameliorating after-effects of heart disease, high blood pressure or cerebral accidents, and so forth, is outside the realm of public health. If as practicing physicians you could do the whole job, that would be true. Certainly diagnosis and treatment (and increasingly prevention of illnesses) are best done by practicing physicians in a doctor-patient relationship on an individual basis. This is "best for the public".

There are some aspects of the over-all operation that practicing physicians are not in a position to do or do as well. As our own Dr. Gunnar Gundersen, President-elect of the American Medical Association, has said so well, "It takes two kinds of physicians to promote and pursue the goal of best possible health for all—one who treats the individual, and one who treats the community as an individual."

I hope you have read and carefully weighed the quotations from his recent address to public health physicians, "IT TAKES TWO", on the back of your annual meeting program.

Now to the two new developments that involve this teamwork, "It Takes Two" concept:

The one is a pilot study on a demonstration basis being inauguarated in the Green Bay area to find out what can be done for bedridden, older patients in nursing homes to restore them to as complete an ability to care for themselves (sit up, feed themselves, dress, go to the bathroom, and so on) as possible.

In several places in the country it has been shown that early ambulation following a cerebral accident in patients who have a will to make the effort results in their being helped to sit up and to get about with the help of crude, simple mechanical devices so that they need not just lie flat in bed for months or years, vegetating unhappily, in constant need of having everything done for them, such as feeding, bed pans, soiled bed linen, and so forth.

If, as early indications point out, 50 per cent of the elderly bed patients in nursing homes suffering from after-effects of the chronic diseases can be helped substantially, then such a development would be good for the patient—very good—and good for the doctor. If this works for elderly patients in nursing homes, it can be applied eventually for the benefit of the other 95 per cent of those over 65 who are not in nursing homes but in their own home or those of their children or relatives.

Obviously, it is practical to start with a demonstration where prospects of being able to evaluate the outcome are brightest. If it proves to be successful, the patients will be happier and more independent, and their cost of care will be substantially reduced.

"Socialized medicine", did someone say? Let's take a closer look.

First, the whole proposal is taken to the county medical society for consideration, approval and follow-through. These are patients practically all of whom are suffering from a chronic disease, about half of whom are capable of being helped. Their own doctor knows best what their condition is and what the prospects of their being helped may be.

If there are reasons why he would like consultation for orthopedic, cardiac, cerebral hemorrhage or other complicated conditions, he requests consultation. The usual fee for his examination and that of the consultant, if one is called, is paid from the funds made available to the State Board of Health for this pilot demonstration. Subsequently, in six months or whenever deemed proper, the patient is again examined to measure progress—results.

There are many aspects of this type of demonstration, such as explaining all of this to the nursing home operators to get their approval and cooperation; to local agencies, such as public health nursing, VNA, welfare agencies, and so on, to get it under way and to make clear that inherent in the activity is a moral obligation to take over for continuous operation after the undertaking has proven itself as being feasible and productive, and so forth.

Physicians cannot be expected to take time to do all this, nor to provide the proposed two physiotherapists to do physiotherapy. In two or more years, however long it takes, the demonstration is over and the community takes over if it is convinced the service is worthwhile and they want to

continue. Possibly that deserves labeling as "socialized medicine". Your State Board of Health, your Commission on State Departments of the Society, and the Brown County Medical Society say it is a worthy project. Let's go!

The other new development, not well understood by some, is also an experimental project, namely, that of trying out what can be learned by way of taking blood pressure readings of the people coming to one of the Board's three Survey Bus X-Ray Units. Call it screening for hypertension, if you like.

Those whose single reading is found to be above 160 mm systolic or 100 mm diastolic are informed that the findings of their tests make it advisable to go to their physician for a more thorough examination; that from the survey test results it is not possible to tell whether the condition is serious or not; and that the physician named by the screenee has received a more detailed description of the findings and will be able to explain their possible implications and to make further examinations if indicated. The screenee is not informed as to the reading.

Did I hear someone say, "Here we go again, having our old hypertension cases or cardiac patients whom we have been following come back for another check-up they don't need"? Let's take a look.

In our study of the 1955 referrals for heart disease from the Bus Surveys (x-rays) . . . .

> . . . . 75 per cent of those who had answered on their blank that they DO have heart disease were found "negative" as far as their x-ray reports were concerned. They were not referred.
>
> . . . . Of the other 25 per cent, 40 per cent were found by their physicians after referral NOT to have heart disease, even though the x-ray was questionable.
>
> . . . . 60 per cent were found by their doctors to HAVE heart disease.
>
> . . . . Two-thirds of these were NEW findings.
>
> . . . . 1,277 patients out of 1,904 found to have heart disease by their doctors were being seen for that reason for the first time. They were getting needed help from their doctor that they would otherwise not have gotten in practically all instances.

So far we have only crude preliminary data regarding the blood pressure reading phase; 155 of the first 1,186 (14 per cent) had readings of over 160 systolic or 100 diastolic. We don't know yet how many of these were true hypertension cases. We will soon have indications as to whether there are excessive, unproductive referrals.

But if through this means a good number of unsuspected cases of hypertension are discovered earlier, and as a result the doctor can prevent or substantially postpone cerebral accidents and some coronary disease, it will be very much worthwhile. We neither diagnose nor treat these patients. We refer possible cases for determination and whatever follow-through the doctor decides is proper or effective.

Again, how could he do the screening part on this apparently well group? Where is there any interference with doctor–patient relationship?

As we see it, this is another example of how "It Takes Two"—the doctor who treats the individual, and the doctor who treats the community, each in his own sphere of operation, to the good of the public and to the good of the doctor.

Should the undertaking not prove to meet these criteria, it will be discontinued. We will have learned together whether it is effective or not.

May I close with a question: Hadn't we better be doing some of these things together, on the basis of "What is good for the public is good for the doctor"?

REMARKS OF SECRETARY OF STATE BOARD OF MEDICAL EXAMINERS

Dr. T. W. Tormey, Jr.: The 1953 changes in the Statutes granted what are known as Temporary Educational Certificates to a specified number of individuals who are unable to meet the regular licensing requirements. By and large, the individuals accepted under this program are graduates of unapproved foreign medical schools.

The certificates are granted on request of the superintendent of any of the hospitals in this State accredited as teaching hospitals, and are renewable for not more than three years of residency type training beyond the internship, which requires no license. This program, enlarged from twenty-five per year in 1953 to fifty per year in 1957, has afforded training in our hospitals to approximately 160 foreign doctors.

Out of this experience two problems have developed. One is the fact that the specialty boards are requiring anywhere from three to five or more years of training for individuals to qualify for these boards. Along with this, several individuals have called to our attention the fact that the third-year certificate holder has become a valuable person in the hospital machine. Consequently, the Board of Medical Examiners has been urged to investigate the possibility of enlarging the program to allow the certificate holder to complete specialty board requirements in this State when he is most valuable. This may later be taken up with the Public Policy Committee for discussion.

The second problem—that of permanent licensure for certain foreign graduate physicians—has been in some measure resolved by the 1957 Legislature. Under a new Statute we may now accept up to twenty-five foreign doctors per year who can meet the statutory and Board requirements.

Recently I kept a count of inquiries from foreigners seeking information about licensure, and in a two-month period had sixty-five such inquiries. This would indicate a possible 350 to 400 inquiries per year.

In addition to expecting those selected to have exceptional training in American medicine, probably one of the most important requirements is that of furnishing in writing definite evidence of a need for the applicant's services in some community, clinic or institution in the State. We feel that these two requirements will not only assure our people of proper medical care, but will distribute these doctors where they can best serve the public with the least chance of disrupting already established practitioners.

All possible precautions are taken to evaluate the pre-professional and professional education. This last is accomplished through the Board, the Educational Council for Foreign Graduates, and the dean of a reputable medical school before the individual is allowed to take the licensing examination. As of this date the Board has taken favorable preliminary action on eighteen foreign graduates who come under the new law.

Other activities have included the investigation of forty new complaints which have involved physicians, quacks, or others violating the Medical Practice Act. Medical licenses have been surrendered in two instances. The illegal use of the title "Doctor" has been prosecuted. Nine individuals practicing medicine without a license have been taken to court. We await final clarification of the limits of the chiropractors' license so we may more properly evaluate that situation. Many complaints have been investigated only to be dropped because of lack of evidence to substantiate the complaint.

In this past year 345 physicians and 69 physical therapists have been examined and licensed or certified.

The register, soon to be released, contains the names of 4,623 M.D.s and 218 osteopathic physicians.

REFERENCE OF REPORTS

Vice Speaker Hirsch announced referral of reports to the following committees:

To the Reference Committee on Reports of Officers:

Reports of the
- President
- President–elect
- Treasurer
- Secretary
- AMA Delegates
- Editorial Board
- Commission on State Departments
- Committee on Diabetes

To the Reference Committee on Reports of Standing Committees:

Reports of the
- Council on Medical Service, including March of Medicine and Industrial Health
- Council on Scientific Work
- Committtee on Civil Defense
- Committee on Public Policy
- Committee on Coordination of Medical Services
- Committee on Hospital Relations

To the Reference Committee on Resolutions and Amendments to the Constitution and Bylaws:

Reports of the
- Council
- Foundation
- Commission on Medical Care Plans, including Medicare and Veterans Medical Service Agency
- Resolutions 1—14 inclusive
- Dues for 1959

Vice Speaker Hirsch announced the time and place of the Reference Committee meeting. He commented:

"It is a privilege as well as an opportunity for any interested member of the Society to appear before these Reference Committees and present his views on any matter properly before them. Delegates who are interested in any particular matter are especially urged to be present."

COMMITTEE ON NOMINATIONS

Following a Councilor District caucus of delegates, on motion of Dr. D. M. Willson, Milwaukee, seconded by Dr. C. J. Picard, Superior, carried, the following delegates were approved as members of the Nominating Committee:

First District _____L. W. Schrank, Waupun
Second District _____H. L. Schwartz, Kenosha
Third District _____P. B. Golden, Madison
Fourth District _____W. D. Hamlin, Mineral Point
Fifth District _____A. C. Engel, New Holstein
Sixth District _____George Schwei, Winnebago
Seventh District _____J. P. McCann, La Crosse
Eighth District _____C. E. Koepp, Marinette
Ninth District _____M. V. Overman, Neillsville
Tenth District _____O. G. Moland, Augusta
Eleventh District _____C. J. Picard, Superior
Twelfth District _____S. W. Hollenbeck, Milwaukee
Thirteenth District ___Marvin Wright, Rhinelander

RESOLUTION OF CONGRATULATIONS

Dr. J. J. Satory, La Crosse, requested and received the unanimous consent of the House to present the following resolution on Dr. Gunnar Gundersen:

"Whereas, this State and its medical profession is honored by the selection of Gunnar Gundersen, physician and surgeon of La Crosse, as incoming President of the American Medical Association in the year 1958, and

"Whereas, our colleague has served his profession in manifold ways, culminating this year with election to the highest office in the medical profession, and

"Whereas, his leadership and example in health and civic endeavor have been a distinct service to the people of our State; now, therefore, be it

"RESOLVED: That this House of Delegates and Council spread upon its records this resolution of congratulations to Gunnar Gundersen, of La Crosse, Wisconsin."

On motion of Doctor Satory, seconded by several, carried, this resolution of congratulations was unanimously adopted.

RESOLUTION FROM THE WISCONSIN STATE DENTAL SOCIETY

Speaker Hildebrand read the following resolution from the Wisconsin State Dental Society for the information of the House:

"Whereas, the Wisconsin State Dental Society has enjoyed uniformly close professional relationship with the State Medical Society of Wisconsin, and

"Whereas, the State Medical Society of Wisconsin has conducted a successful prepayment program offering medical and surgical services to the people of this State for more than a decade, through a division known as Wisconsin Physicians Service, and also known as Blue Shield of Wisconsin, and

"Whereas, the said plan has become widely recognized for its willingness to experiment to the end that the plan may meet an increasing proportion of the health needs of our population, and

"Whereas, the State Medical Society of Wisconsin has recently announced that it is prepared to offer a rider covering certain types of dental surgery under an arrangement whereby it will pay the usual, reasonable and customary fees of the dental community in which the service is performed; and the said Society has requested the establishment of a liaison committee by the incoming President of the Wisconsin State Dental Society, for meetings to begin shortly after May 1, 1958; be it, therefore,

"RESOLVED: That the Wisconsin State Dental Society extend its good wishes, and its congratulations to the State Medical Society of Wisconsin for the accomplishments of Wisconsin Physicians Service in the health interests of the people of this State, and also express its appreciation of the initial recognition by that plan of some types of dental service; and be it finally

"RESOLVED: That this Society pledge its continuing cooperation to the State Medical Society of Wisconsin in this and other matters of common interest designed for betterment of the health of the people of this State."

ADJOURNMENT

The first session of the House of Delegates adjourned at 10:45 p.m.

SECOND SESSION

Tuesday, May 6, 1958

The House of Delegates convened at 7:30 p.m., Dr. W. B. Hildebrand, Speaker of the House, presiding.

REPORT OF COMMITTEE ON CREDENTIALS

The Committee on Credentials verified the registration of 46 delegates and 16 alternate delegates entitled to vote at this session of the House of Delegates. In addition, 9 alternate delegates and 3 councilors registered their attendance. The Credentials Committee also reported that the Portage County Medical Society had duly appointed Dr. W. A. Gramowski, Stevens Point, to act as delegate for that Society in place of the regular delegate and alternate who were unable to attend.

On motion of Doctor Hirsch, seconded by Dr. E. J. Nordby, Madison, carried, the attendance roll of delegates, alternate delegates and specially appointed delegates totaling 62 was accepted as the official roll of the second session of the House to stand for the entire session.

Subsequent registrations brought the total number of delegates and alternate delegates entitled to vote to 72.

INTRODUCTION OF GUEST

Speaker Hildebrand introduced Dr. George Slagle, Battle Creek, Michigan, President of the Michigan State Medical Society. He made the following remarks:

"I know that you have many, many serious problems before you tonight and during this meeting, the same as we have in Michigan. I am reminded of two things I would like to say. The first part of last week it was my privilege and that of several people in this room to hear Professor Pallyea talk to the Blue Shield–Blue Cross national meetings in Chicago, and he made a couple of remarks that I think are very important.

"He has been a student of federal and state government and medicine for years. He took us from the time of Bismarck up to the present. He stated, first, that, disregarding our veterans' program, we in the United States could qualify as one of three nations that do not have federal or government medicine. The other two are Finland and Switzerland. All the rest have one degree or another of federal government control.

"The second point he brought out was the fact that in any of these countries it was not a question of the doctor's charges or fees, whether they be too high or too low, but it was a question of the machinations of politicians or groups of politicians who foisted governmental medicine on the people and on the medical profession. I think that is something we should all remember.

"The matter of flank attacks, due to the Forand bill and similar things like it, is very definite and very pertinent at this time. Your President, Doctor

Kasten, earlier this evening made remarks that I can only echo right now as far as my feelings are concerned. The matter of unity alone is not enough. We not only have to be unified and work toward something, but we have many, many serious problems ahead of us.

"We in Michigan, as you well know, through our extended benefits of Blue Shield, are combatting Mr. Walter Reuther and his Community Health Association plans for closed panel practices which would definitely do away with the free choice of physician. Throughout the country it is widespread.

"Last Sunday morning the newspaper headlines in this area and probably throughout the whole country stated that unions are fighting the American Medical Association. We are the American Medical Association, and we have to fight that battle and try to preserve the heritage we have been given by our forefathers in the matter of the practice of medicine and the matter of the free practice of medicine.

"I like to say 'the free practice of medicine' rather than 'the practice of free medicine', because we know nothing is free. I do think we must fight this, and all of us in our area, including the entire United States, must be bound together because of these things.

"It is certainly a great pleasure to be here. Those of you whom I do not know I hope I will have a chance to meet personally and discuss things with you, because I can learn a lot from you folks, too."

SUPPLEMENTARY REPORT OF THE DIVISION ON MATERNAL AND CHILD WELFARE, MATERNAL MORTALITY STUDY COMMITTEE

Dr. T. A. Leonard, Madison, Chairman: As you will recall, the members of the House five years ago made it possible for us to set up a Maternal Mortality Study Committee with the purpose in mind of determining in the State of Wisconsin what the major causes of maternal demise were, and then subsequently to see what we could do about reducing the maternal death rate in this state.

It has been very gratifying for the members of the Committee to work on this project and briefly to report to you that in the five years this study has been in force, the maternal death rate in Wisconsin has been reduced 50 per cent.

We have reviewed 199 deaths out of 365,000 live births in the State. Obstetric deaths accounted for 111 of those deaths. We have determined in this study that the major causes of maternal demise were those due to toxemia, hemorrhage, those due to the medical complications of pregancy, and those due to anesthesia.

Subsequently we set up a series of teaching programs in order to bring to the men in the State who are practicing obstetrics the latest methods for the management of these serious and tragic consequences in pregnancy, in order that by the application of these means we may still further reduce our maternal mortality figures.

The most satisfying and gratifying thing we have done has been during the past year, and that was to conduct a teaching circuit with sessions at Madison, at Milwaukee, at Wausau and at Eau Claire. We had approximately 250 physicians in attendance at those sessions. They were conducted by members of the Study Committee, each giving a paper, a case report, and then subsequently a question and answer period followed. We felt that these were very successful, and we intend to enlarge upon this type of program in the future.

We have in the immediate future a plan to present this same type of program to the senior students at Marquette and to the senior students in medicine at Madison.

In addition to this, the Study Committee has had a number of other duties which we feel will further reduce maternal deaths. For example, when the maternal mortality rate becomes low, as it has in Wisconsin, then we must begin to grasp at the strings and the straws. One factor which has contributed to maternal deaths in Wisconsin has been that associated with the migrant worker class. These migrant workers, mostly of Mexican origin, have not had prenatal care. Usually the physician is called upon to attend them when certain complications of pregnancy almost assuredly lead to demise.

We recently had a meeting with the Governor's Commission on Human Rights, and we now have under way a program whereby these migrant workers can be given better care.

These are only a few of the things that the Study Committee is doing. Most of us who have been engaged in this work have felt that we have had a little part in contributing to the betterment of medical practice in Wisconsin and specifically to the betterment of obstetric practice in this State.

We have appreciated very much the understanding of everyone which has grown out of this study over a period of five years. When we began, of necessity there were certain mistakes that we could not foresee. We have tried to correct them. We feel now that this is a cooperative effort between the physician and the Study Committee for the mutual good of the childbearing woman.

Thank you very much for the opportunity of giving you this brief report. We are going to continue this study, and we hope to save still further the lives of women in childbirth.

REMARKS OF THE DEAN OF MARQUETTE SCHOOL OF MEDICINE

Dr. J. S. Hirschboeck: It is indeed a privilege for me to be here once again and to speak a word or two about medical education in our State as I see it, with particular reference to the Marquette University School of Medicine.

It seems to me that there are three main points that I would like to make this evening. The first has to do with an obligation which medical schools have

—ours as well as others. The obligation is that of training so many new ancillary professional people in the health field.

At the last tally I believe it was stated that there were 132 people of professional or technical status working in the health field. This is quite a figure to comprehend when we consider such groups as the medical technologists, physical therapists, clinical psychologists, the residents, the medical record librarians, the medical assistants, and so on. We can realize that this problem of education at the vocational and even in many instances at the collegiate and postgraduate level is becoming quite a formidable problem for medical schools.

I mention this only to call attention to the fact that the medical profession is the mother profession for all of these, and we as medical educators feel that we must rely quite heavily on your cooperation in keeping all of these ancillary groups within the orbit of medicine.

I mention this to point out that medical schools in our State, as well as elsewhere, need your encouragement to do all that we can within our limits to support these ancillary groups.

The sceond point I should like to make has to do with a problem in medical education as I see it, namely, the reorientation of curricula and teaching more toward the patient as a whole person. We have seen so much splintering as a result of the many advances in medical science.

I mentioned earlier these ancillary groups. The poor patient seems to be divided up more and more into parts that need to be brought together. I think this is one of the great challenges of medical education today, to try on the one hand to preserve and advance all of the wonderful advances in medical science and medical practice, and at the same time reorient our teaching more closely toward the patient as a person and family, and all of these intimate, personal things which were so much the success of medicine as it was practiced for centuries.

This is a great challenge for medical schools, and here too we need the sympathy and cooperation of all men in practice to help us achieve this goal.

Finally, the problem that I consider a major one in medical education today is the availability of an adequate number of teaching cases in our medical schools. There has been a great change in medical practice in university settings over the last decade, much more of a change than occurred for many decades before.

The changing economic status of patients, the changes in health care, the Hill–Burton hospital program building hospitals all over the United States —all of this has changed the complexion of patients in medical schools. This is a great challenge for the medical profession. If we are to continue on the road of progress of medical education, we need to have an adequate supply of teaching material in our medical schools.

Some of them are in much more critical state than others. Believe me, this is a national problem, not only local. It is one of the great concerns of medical educators. I mention it only to call your attention to the fact that it is serious, and that both schools in this State sooner or later will begin to rely in great measure on one type or another of private patient for teaching purposes.

It seems to be inevitable. I mention it only to tell you that to me this is a very serious problem in some areas now, and certainly will be more of a problem in the future.

Again, may I say it has been a pleasure to talk to you in these general terms. Perhaps I should say a word about our own schools.

We are continuing to fight the battle as best we can. As all of you know, and as I have said here so many times, our main problem is a financial one. We are always confronted with a deficit at the end of the year. It seems to turn in such a way that it is like the dog who is surviving by eating its own tail. It can't go on forever. We hope that soon some solution will be in the offing not only for our school but for many other medical schools in the country that are confronted with this problem.

REMARKS OF THE DEAN OF THE UNIVERSITY OF WISCONSIN MEDICAL SCHOOL

Dr. John Z. Bowers: Let me say, first of all, that it is a very real pleasure to appear before the House of Delegates to discuss the program at the University of Wisconsin Medical School. As you are aware, these are days of change in our medical school. We hope they are in a direction and in a manner that will bring credit to the medical profession of our State.

The great bulk of clinical material referred to the University Hospitals in Madison today is from the chronic, complicated diseases; cancer and the degenerative vascular diseases are our major problems. This, of course, has placed serious limitations on our teaching program in obstetrics and pediatrics, which we are meeting in part by establishing educational affiliations with other hospitals in Madison and through our preceptor programs.

But these are not enough. Medical education today also emphasizes the ambulatory patient to a far greater degree than in the past, and here we also face shortages.

In order to meet these shortages we have been holding a series of very fruitful and helpful conversations with representatives of the State Medical Society, and we feel that this is the way to solve our problems.

Second, let me say that I have not been satisfied with our program in postgraduate medical education particularly in regard to courses at the Medical Center, and we are taking steps to bring this up to the mark. In July you will receive a notice of courses to be offered next year. New courses will be initiated. The number of visiting speakers will increase. We will make your room reservations. We will use more patient material, and we will have a dinner at the

headquarters of the State Medical Society during each course.

We want to shift your thinking in postgraduate medical education from Minneapolis to Madison.

One of my most gratifying experiences during my stewardship in Wisconsin has been to watch the development of our Alumni Association. A Medical Library, for which they will very soon open a fund-raising campaign, is desperately needed. A new library will also permit us to do a far better job for supplying library material to the physicians of our State.

Since I appeared before you two years ago many new men have been added to our faculty, some to replace distinguished faculty members who have died, others to expand the program. For example, we have three new men in gynecology and obstetrics, four new men in psychiatry, and as of July 1 there will be five new men in pediatrics. In total there are thirty-six new medical faculty members at Madison since May 5, 1956.

These men, I can assure you, are anxious to work with the practicing physicians of our State, and I hope you will invite them to address your local medical groups so that you can get to know them.

We are now admitting 100 students per class. I thought you might be interested in some figures on the total teaching load in the health sciences at Madison today. We have 350 medical students, 116 students in occupational therapy, 140 students in physical therapy, 302 nursing students, fifteen x-ray technician students, ten students in medical technology, sixty graduate students, eighty-four interns and residents, making a total of 1,032 students in the health sciences. In 1927 there was a graduating class of twenty-five students. So, things have changed.

We must be constantly attentive to the need for the recruitment of well-qualified young people for medicine. The need for engineers and for nonmedical scientists has been widely publicized, and possibilities in these fields represented as most attractive. Medicine, on the other hand, is usually portrayed as requiring long and expensive training, a hard working life, and constant study. These things are true. We overstress these factors, however, without presenting the infinite variety of medicine, the respect with which physicians are usually held, and the fact that the monetary rewards are commensurate with our contribution to society.

I wonder how many members of the State Medical Society would change places with our neighbors in other occupations.

REMARKS OF DR. H. KENT TENNEY, PAST PRESIDENT

Dr. H. Kent Tenney: Many of the things that have been said to you in the last few minutes strike very close to my heart, as I have been associated with the University of Wisconsin Medical School for thirty-eight years and six days. I joined that faculty on May 1, 1920.

During that time I have seen many, many developments, and I have been privileged to watch developments in the school. There is one thing that stays with anyone who has been associated with that school as an experience unique in life, and that is the spirit that activates the faculty of that medical school. Constantly it is kept in the forefront of their thinking. It is the welfare of the private practitioner of medicine.

Throughout the history of medicine the profession has taken a responsibility toward medical education. Hippocrates was the first one to mention it in his renowned Oath, when he said, "I will impart a knowledge of the Art if they should so desire it, without fee or stipulation." We might not go along with that completely [laughter], "but that by every precept, lecture and other mode of instruction I will impart to them a knowledge of the Art."

The counterpart of that statement of Hippocrates is found in our American Medical Education Foundation, where physicians are being asked and are responding to the request to perpetuate their profession. It is a unique experience in our society, I believe, that a profession goes out on a financial limb to see to it that it is perpetuated and that their medical schools do not suffer.

Along with that, though, has gone the request from medical schools to physicians for advice and counsel in their ways of teaching and in the methods of procedure, and that is shown in what Dr. Bowers has said and what Dr. Hirschboeck has said, that in medical schools we not only want financial support but the deans of every school want the advice and counsel of the physicians of the state. This action recently, in asking a committee of the State Medical Society to help devise methods of getting more teaching material, is a very good demonstration of that.

Then, this matter of getting students interested in studying medicine: Certainly it is true that we are competing with industry for the same type of intellectual persons, and the industries have something apparently to offer that we don't have, and that is a quick financial return.

Therefore, I believe it is up to every physician who has any contact with patients, particularly with young patients, to let them know the gratifications and the satisfactions that are found in the practice of medicine in addition to a decent financial reward. We cannot appeal to these youngsters entirely on a financial basis, but we as physicians can let them see that the life of a physician has something to offer that maybe the drawing board does not have.

Speaker Hildebrand introduced Mr. Marvin Chapman and Mr. Donald Schmidt, medical students representing the Wisconsin Chapter of the Student AMA at the University of Wisconsin Medical School.

REPORT OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS

The Reference Committee was composed of: Drs. E. D. Sorenson, Elkhorn, Chairman; Donald M. Willson, Milwaukee; H. A. Aageson, Oconto; P. H.

Gutzler, River Falls; and R. W. Mason, Marshfield. Doctor Sorenson presented the report.

The Reference Committee reported its review of the Reports of the Council and acknowledged its efforts on behalf of the Society. The Council requested, and the Reference Committee recommended, four changes in the bylaws, namely:

That Chapter VI, Section 6, be amended to read:

"The Council shall adopt an annual budget providing for the necessary expenses of the Society, which shall be prepared and presented for its consideration by the Treasurer and Secretary at the first meeting of the Council each year."

Second, that Chapter VI, Section 6 be amended by addition of the following final sentence:

"The Council may elect a Vice Chairman and create such further offices or combine or abolish them as it sees fit in the management of its affairs and in the discharge of its responsibilities."

Third, that Chapter XI, Section 8 be amended to require county medical societies to report names of their delegates by the end of the calendar year preceding the year in which such delegates are elected to serve.

Fourth, that Chapter III, Section 9 be amended to the effect that resolutions to the House be filed with the Secretary thirty days prior to the first session of the House.

On motion of Doctor Sorenson, seconded by Dr. E. A. Strakosch, Oshkosh, carried, this portion of the report was accepted.

The report of the Commission on Medical Care Plans as it appeared in the Delegates' Handbook was recommended for careful re-reading by each delegate. The Reference Committee directed special attention to the growth of the special service contracts and to the part played by the county medical societies in providing special claims services.

On motion of Doctor Sorenson, seconded by Dr. J. G. Beck, Sturgeon Bay, carried, this portion of the report was accepted.

Appreciation was expressed for the completeness of the reports on Medicare and the Veterans Medical Service Agency and the Reference Committee recommended their re-reading by all members of the House.

On motion of Doctor Sorenson, seconded by Dr. R. S. Gearhart, Madison, carried, this portion of the report was accepted.

The Reference Committee recommended approval of the recommendation that the voluntary billing to physicians for contributions to the Society's Charitable, Educational and Scientific Foundation be continued at $10.00 for the 1958–1959 fiscal year.

It also approved the recommendation of the Council that the Board of Trustees for the Foundation create a committee expressly in the area of the American Medical Education Foundation to develop appropriate mechanisms to increase Wisconsin's contributions to that Foundation.

On motion of Doctor Sorenson, seconded by Dr. H. J. Kief, Fond du Lac, carried, this portion of the report was accepted.

The Reference Committee recommended that dues of the State Medical Society of Wisconsin for 1959 remain at $75.00.

On motion of Doctor Sorenson, seconded by Dr. A. J. Sanfelippo, Milwaukee, carried, this portion of the report was accepted.

The Reference Committee reported that it had considered resolutions nos. 1, 2 and 3 together, since they pertained to the subject of social security—namely, a poll regarding views on compulsory social security and two favoring it. The Committee recommended rejection of these resolutions for the following reasons:

(1) Social security as financed represents a second income tax on gross income, with ultimate rates of no less than 10 per cent by government acknowledgement, and with possible income ceilings of $7,500 to $10,000 a year already proposed in the Legislature.

(2) Because few physicians retire at age 65, it is felt this is too big a burden for the young physician to bear over his lifetime for the relatively slight protection offered in his youth.

On motion of Doctor Sorenson, seconded by Dr. E. A. Strakosch, Oshkosh, carried, this portion of the report was accepted.

Resolutions nos. 4 and 16, relating to the Forand–Proxmire and similar bills were considered together. The Reference Committee recommended that the introductory portion of resolution no. 4 remain unchanged but that the final paragraph read as follows:

"Now, therefore, be it

"RESOLVED: That the State Medical Society of Wisconsin oppose the Forand, Proxmire and similar bills in their provisions for hospital-surgical benefits under the conditions which have been outlined above, and suggests that the Congress authorize a thorough study of the entire social security program, including the needs of the aging."

The Reference Committee further recommended that resolution no. 16 be adopted as submitted.

On motion of Doctor Sorenson, seconded by Dr. H. J. Kief, Fond du Lac, carried, this portion of the report was accepted.

The Reference Committee concurred in resolution no. 5 submitted by the Dane County Medical Society and recommended that the House of Delegates formally record the appreciation of the State Medical Society of Wisconsin to the Racine County Medi-

cal Society for its pioneering efforts in the experimental development of a program of prepaid health care insurance which eliminates the conventional structure of schedule of benefits and pays for services in the usual, reasonable and customary amount charged in the area where such services are rendered. The Committee recommended the adoption of the resolution.

On motion of Doctor Sorenson, seconded by Dr. P. B. Mason, Sheboygan, carried, this portion of the report was accepted.

Resolution no. 6 submitted by the Third Councilor District, with respect to the Medicare program, was accepted by the Reference Committee with the exception that the final paragraph containing the resolution itself was changed to read as follows:

"Now, therefore, be it

"RESOLVED: That this House of Delegates commend the Council and the Commission on Medical Care Plans for their efforts in this problem of segmentation of fees for surgical services in the administration of Medicare."

On motion of Doctor Sorenson, seconded by Dr. S. W. Hollenbeck, Milwaukee, carried, this portion of the report was accepted.

The Reference Committee felt that the House of Delegates and the profession generally must be concerned with all branches of medicine as they relate to the health of the public and therefore recommended the adoption of resolution no. 7 urging the Council and Commission on Medical Care Plans to include in its Blue Shield plan benefits for the services of radiology, anesthesiology, pathology and physiatry.

On motion of Doctor Sorenson, severally seconded, carried, this portion of the report was accepted.

The Reference Committee considered resolutions nos. 8, 9, 10, 11 and 12 together. It reported as follows:

"The Reference Committee has been impressed with the sincerity and motivation of all concerned in the presentations which it heard this morning. The Reference Committee wishes to recommend that resolution no. 8 be rejected, but that the Council consider the desirability of authorizing and implementing such a study, the results of which would be presented to the delegates and the members of the Society."

In view of this recommendation, we also recommend that resolutions nos. 9, 10, 11 and 12 be rejected.

On motion of Doctor Sorenson, seconded by Dr. G. P. Schwei, Menasha, carried, this portion of the report was adopted.

In relation to resolution no. 13, the Reference Committee reported as follows:

"Your Reference Committee finds itself highly in accord with resolution no. 13, urging continuation of a companion relationship of Wisconsin Physicians Service to Blue Cross, fostering it through sales, promotion, advertising and similar efforts, and to invite those associated with Blue Cross to reciprocate in support of Wisconsin Physicians Service as a companion plan. The Reference Committee recommends adoption of this resolution."

On motion of Doctor Sorenson, seconded by Dr. P. B. Golden, Madison, carried, this portion of the report was accepted.

Resolution no. 14 requested the development of a recommended uniform schedule for use by all county welfare departments in Wisconsin. After due consideration the Reference Committee reported that it "does not feel this resolution should be adopted because of the recognized difficulty in establishing public assistance fees in various areas throughout the State."

On motion of Doctor Sorenson, seconded by Dr. R. W. Kreul, Racine, carried, this portion of the report was accepted.

On motion of Doctor Sorenson, seconded by Dr. P. B. Blanchard, Cedarburg, carried, the report as a whole was adopted.

REPORT OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES

This Reference Committee was composed of Drs. G. W. Carlson, Appleton, Chairman; J. P. McCann, La Crosse; H. M. Templeton, Barron; A. J. Baumann, Milwaukee; and E. W. Humke, Chilton. Doctor Carlson presented the report.

Special commendation was given the Council on Medical Service and its chairman, Doctor Devitt, for taking medicine's case for better health to the public through mass communication. The Reference Committee concurred with the Council on Medical Service in its efforts to eliminate the misunderstandings of newsmen in what is right to know on behalf of the public and the right of privacy as seen by the physician on behalf of his patient. Attention was directed to a series of conferences with representatives of the news media in Wisconsin to establish a guide on medical-press-radio-TV relationships, the television programs of the Society, The March of Medicine, distribution of health literature and health exhibits. The Reference Committee recommended that the State Medical Society strongly re-emphasize again in this report, as it did in last year's report, its sincere and continuing concern for the welfare of the patient and all the professional, social, economic and political factors contributing thereto.

On motion of Doctor Sorenson, seconded by Dr. M. T. Morrison, Mount Horeb, carried, this portion of the report was accepted.

The Reference Committee commended Dr. L. G. Kindschi and his excellent Council on Scientific Work for their contributions to the advancement of scientific knowledge and the direct service provided

to the membership. The outstanding annual program this year deserves the entire support of the State Medical Society for its continued success. The diversification of the program should appeal to the entire membership. The Reference Committee recognized the value of the various circuit teaching programs with the leadership of faculty members of the two medical schools and to be used increasingly as circuit staff. The Reference Committee reviewed with interest and concurs in exploring a type of teaching described as a hospital consultation service under which two hospital staffs will be offered the services of faculty members from the two medical schools for morning Clinical Pathological Conferences and direct bedside teaching. This program is to be evaluated and reported to the general Council in 1959. The Reference Committee commended the Council for utilizing the round table luncheons as a part of the scientific program.

On motion of Doctor Carlson, seconded by Dr. E. J. Nordby, Madison, carried, this portion of the report was accepted.

The Reference Committee carefully considered the Report of the Committee on Civil Defense so ably headed by Dr. E. P. Ludwig, Wausau. The Committee expressed the belief that the House of Delegates should be mindful of the progress it has made in civil defense during the past ten years. After reviewing the report the Reference Committee drew attention to the following sections of the report:

1. The Wisconsin civil defense program as to terminology, responsibilities and organization is now well-defined.

2. The Committee has contributed greatly in the completion of the State Survival Plan, which includes a program for health services.

3. The State Survival Plan embodies a well-developed, coordinated effort to correlate on a State level a compact program for the care of the populace in case of disaster.

4. The Committee agrees that the new State Survival Plan should be extremely helpful to all county medical societies in its description of responsibilities in communications from the health standpoint.

5. The Committee has worked with State Health Officer Doctor Neupert, who is also co-director of Health Services for Civil Defense. In organizing a program for the development of blood collecting centers in every county in Wisconsin with a population of 20,000 or over, the interest manifested in civil defense by hospitals and county medical societies to handle natural disasters has been heartening.

On motion of Doctor Carlson, seconded by Dr. J. J. Satory, La Crosse, carried, this portion of the report was accepted.

In reviewing the Report of the Committee on Public Policy the Reference Committee called attention to the great amount of work being done by Doctor Quisling and his Committee. The report stressed the importance of physicians aiding in the education of their patients and legislators concerning good public health measures and the need for protection against quackery and cultism. The Reference Committee expressed pleasure with the prompt response of county societies to the request of the House last year for the organization or reactivation of county public policy committees. The Reference Committee expressed confidence that the county units will be supplied with full information on legislative issues. The effectiveness of the Society's medical and public health efforts will be determined by the degree of cooperation between the state and county public policy committees.

On motion of Doctor Carlson, seconded by Dr. Gordon J. Schulz, Union Grove, carried, this portion of the report was accepted.

The work of the Committee on Coordination of Medical Services was reviewed in some detail. The Committee is under the leadership of Doctor Gearhart and serves as a special committee of the House of Delegates dealing with problems of medical education in Wisconsin. Among the factors contributing to the lack of adequate clinical material at the University of Wisconsin are:

(a) The wide development of health insurance plans for all classes has relieved many people of the burden of unplanned catastrophic illnesses and is treated today in their own particular localities.

(b) The wide distribution of well-trained physicians working in well-equipped hospitals all over the State has eliminated the necessity of referrals to medical teaching centers having specialized medical facilities.

(c) And the advent of vaccine against poliomyelitis by Salk has reduced markedly the orthopedic cases. The clinical shortage also has reflected itself in other clinical branches of medicine, especially in obstetrics, in pediatrics and other specialties.

The Reference Committee pointed out that the Committee during the past eighteen months, with the aid of the staff of the Society and others, had been in repeated conferences as to the problems concerning the University of Wisconsin Medical School in particular. The Committee on Coordination of Medical Services offered the following recommendations:

1. That the University be encouraged to develop its student health program, to the end that it provides students with 24-hour and seven-days-a-week service. This in itself will encourage the enrolled student to greater use of the service, and from that service he may be directly referred to the University Hospitals for other needs.

2. That the University, upon a reasonable rate basis and upon choice of the undergraduate student, be privileged to provide the students and their spouses and children with their medical care.

This recommendation, if carried into effect, would provide a family of about 14,000 young people (of these only 15 per cent are married and relatively few

have children) for whom the medical faculty could be medical advisers and consultants.

3. That the House of Delegates approve in principle the acceptance of obstetric cases at the University of Wisconsin from sources other than referred to in paragraph 1 at a reduced special rate, or State–county per diem, such rate to be established after further studies and in conference with University and State officials.

4. That the House of Delegates approve in principle the creation of a domiciliary facility to which the unwed mother may be referred, such facility to be in the neighborhood of the Medical School, and its services made known through appropriate health and welfare channels.

5. That this House of Delegates authorize the Council, the Committee on Coordination of Medical Services, and other appropriate groups within the Society structure to emphasize to the entire membership these problems of medical education, urging that the individual physician recognize and fully assume his share of responsibility in referring not only to the University of Wisconsin but to Marquette University and other medical centers such cases as may be properly referred, not alone for education purposes but to provide highly specialized services perhaps not elsewhere so immediately available.

The Reference Committee was fully in accord with the provisions of the recommendations and favored their acceptance by the House of Delegates. It further believed that the passage of these recommendations would aid in relieving some of the major problems facing the University of Wisconsin Medical School and at the same time would be of considerable assistance to the Marquette School of Medicine.

The Reference Committee felt that the House owed the Committee on Coordination of Medical Services an expression of sincere appreciation for its concerted and devoted effort on behalf of the medical profession of this state and in the interests of the secure future of the medical schools.

On motion of Doctor Carlson, seconded by Dr. G. C. Hank, Madison, carried, this portion of the report was accepted.

The Reference Committee reviewed the report of the Committee on Hospital Relations which at the last session of the House of Delegates urged the initiation of hospital relations field service for early 1958. This was begun with the addition to the staff of a former hospital administrator who carries the title of Consultant in Hospital Relations. The Reference Committee pointed out that a three-month period of activity was not adequate to provide a conclusive report, but it was evident that service to both administrators and medical staffs has been one of substantial value.

In reviewing the report of visits to about thirty hospitals in various parts of the state, the Reference Committee recognizes that discrepancies between the medical staffs, the hospital boards and administrators as to sound and efficient hospital operation are apparent. The lack of good and workable bylaws of many of the hospitals apparently causes differences which can be resolved only by revitalizing the interest of physicians. The Committee on Hospital Relations will provide a more complete review of physician-hospital relationships in Wisconsin for the House of Delegates session in 1959. The Reference Committee asked the Committee on Hospital Relations to send copies of the completed report to all hospital medical staffs for their review at one of their staff meetings and that such a report also be sent to hospital authorities of all hospitals in Wisconsin. The Committee commended Doctor Henske and his Committee for the splendid job they are doing.

On motion of Doctor Carlson, seconded by Dr. T. E. Boston, Hillsboro, carried, this portion of the report was accepted.

Resolution no. 15, introduced by the Manitowoc County Medical Society, was discussed at length. The Reference Committee was in full support of the intent of the resolution and expressed the belief that it could be given added strength by a substitute resolution as follows:

> "Whereas, the normal channels of drug distribution were bypassed in the distribution of polio and flu vaccine, particularly during the periods of short supply, and
>
> "Whereas, this virtually destroyed the opportunity for medical societies and public health groups to apply effective priorities for administration; now, therefore, be it
>
> "RESOLVED: That this House of Delegates express dissatisfaction with the distribution of vaccines and similar drugs directly to nonmedical groups, thus bypassing both physicians and pharmacists; and be it further
>
> "RESOLVED: That the House request the AMA to make every reasonable effort, in cooperation with national pharmaceutical groups and public health officials, to prevent similar occurrences in the future; and be it finally
>
> "RESOLVED: That the House of Delegates of the State Medical Society affirm its conviction that the most effective method of administering vaccines in each community of the State is a matter best determined by the local county medical society."

On motion of Doctor Carlson, seconded by Dr. E. D. Sorenson, Elkhorn, carried, this portion of the report was accepted.

The Reference Committee recommended that the House commend all committee members for their efforts on behalf of the Society, hours spent away from their busy practices in the interests of all members of the Society, and in the interests of good public health. The Reference Committee also recognized the most able assistance rendered by the office staff in Madison on behalf of the Society.

On motion of Doctor Carlson, seconded by Dr. H. J. Kief, Fond du Lac, carried, this portion of the report was accepted.

On motion of Doctor Carlson, seconded by Dr. P. B. Golden, Madison, carried, the report as a whole was adopted.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS

This Reference Committee was composed of Drs. R. S. Gearhart, Madison, Chairman; C. J. Picard, Superior; Gordon Schulz, Union Grove; L. L. Olson, Darlington; and Gorton Ritchie, Milwaukee. Doctor Gearhart presented the report.

The Reference Committee reviewed in detail the report of the President. He was commended highly for the details of Society activities which he reported to the House. Doctor Kasten had made unity the major theme of his administration and admits that it may still be a major defection. He urged physicians to endeavor to place American medicine in its proper niche in the puzzle of national and international struggles, and his comment that the State Medical Society of Wisconsin is a dynamic organization dedicated to better and more modern medical services, all in the finest tradition of Wisconsin medicine, should keynote this meeting.

The Reference Committee recommended that his report be accepted with the gratitude of the State Medical Society expressed through this House of Delegates.

On motion of Doctor Gearhart, seconded by Dr. G. W. Carlson, Appleton, carried, this portion of the report was accepted.

The report of the President-Elect, Dr. J. W. Fons, gave expression to many matters important to the profession. He reminded the Committee that the Medical Society is a study group and that the modern physician must constantly be a student, and that at the same time he must be a teacher. Likewise, he called attention to the fact that the man of medicine is part of the team of public health, interested and active in all phases of the health of the public of the State of Wisconsin, and that this state of health always must be achieved through the free choice of physician. Doctor Fons further reminded the members that physicians in Wisconsin can say that they have done their collective best, and it must be some credit to them that their effort has contributed to the growth in prepaid insurance which is regarded everywhere as an economic phenomenon. He proposed that the Society's Foundation and the Section on Medical History collaborate in placing a suitable marker before the early home of Dr. Nicholas Senn, the renowned Wisconsin surgeon, that all might know of the works of one of Wisconsin physicians great colleagues. Doctor Fons expressed the hope that the day is not far distant when the medical profession of America will be able to leaven the dough of controversy and, as a united profession, focus its intent upon the real issues of their chosen field.

On motion of Doctor Gearhart, seconded by Dr. R. F. Inman, Montello, carried, this portion of the report was accepted.

The Reference Committee complimented Dr. F. L. Weston, Treasurer, for an excellent, brief but lucid report. Members of the State Society owe a debt of gratitude to Doctor Weston for his thankless task.

On motion of Doctor Gearhart, seconded by Dr. P. B. Golden, Madison, carried, this portion of the report was accepted.

The report of the Secretary, Mr. C. H. Crownhart, was thoroughly reviewed and the Reference Committee acknowledged his "sincere and honest" report and unanimously agreed upon its acceptance.

On motion of Doctor Gearhart, seconded by Dr. M. D. Davis, Milton, carried, this portion of the report was accepted.

The report of the American Medical Association delegates from Wisconsin had been circulated by mail to every member of the Society and the Reference Committee reviewed and approved this enlightening report.

On motion of Doctor Gearhart, seconded by Dr. R. M. Waldkirch, De Pere, carried, this portion of the report was accepted.

The report of the Editorial Board of The Wisconsin Medical Journal was reviewed "with pride for the high standards exhibited by the Wisconsin journal." Dr. R. S. Baldwin was complimented on the results of his "untiring efforts."

On motion of Doctor Gearhart, seconded by Dr. A. C. Engel, New Holstein, carried, this portion of the report was accepted.

The Reference Committee pointed out that the Committee on Diabetes is one of the newest of the committees and has been able to report for the first time this year. Dr. Karl H. Beck's report entered the plea that accomplishments can be gained in public and medical education in diabetes, and the Reference Committee concurred in his request that the Committee continue its activity.

On motion of Doctor Gearhart, seconded by Dr. L. L. Olson, Darlington, carried, this portion of the report was accepted.

In the report of the Commission on State Departments, Dr. T. W. Tormey, Jr. noted the increasing frequency and complexity of relationships between physicians and agencies of local, state and federal government in the past year. The Commission believes that this mechanism of relationship produces a more stable approach to health problems to the benefit of the public and the medical profession, and at the same time safeguards the professional status and function of the physician. In addition to the reports reproduced in the Delegates' Handbook, the division chairmen appeared before the Reference Committee with supplementary material. Dr. L. M. Simonson, Chairman of the Division on School Health, recommended that each county medical society establish a School Health Committee to function actively on the local level.

Dr. A. M. Hutter, Chairman of the Division on Geriatrics, reported on the constantly increasing activities and demands of the Division on Geriatrics that must keep pace with the ever-increasing numbers of aging population. The Division strongly urges each county society to establish an active Committee on Geriatrics which can receive assistance from the State Committee.

The work of the Division on Chest Diseases was reviewed by Dr. H. A. Anderson, its Chairman. The name of the Division had recently been changed from the Division on Tuberculosis and Chest Diseases to the Division on Chest Diseases, and now includes men whose primary interest is that of cardiology. The work of the Division in the future will be broadened to cover tuberculosis and related diseases of the chest, in particular heart and carcinoma of the lungs.

Dr. E. D. Schwade reported as Chairman of the Division on Nervous and Mental Diseases, explaining its recommendations for a facility for the treatment of the severely emotionally disturbed child. This first facility, perhaps 25 beds, is to be located on or near the University of Wisconsin Medical School campus and operated in close cooperation with the State Medical Society, State Department of Public Welfare and the State Board of Health. The first unit would actually be a pilot project which, if successful, would be enlarged and possibly duplicated in other areas of the state. Doctor Schwade further strongly recommended that all county medical societies become fully acquainted with and attempt to implement to the fullest extent the AMA's guiding principles for relationships with voluntary health agencies on the level of the county medical societies.

The Reference Committee, after careful review of the reports of each of the ten Divisions of the Commission on State Departments, including the above mentioned supplementary reports, recommended the approval of the full report of the Commission on State Departments.

On motion of Doctor Gearhart, seconded by Doctor Olson, carried, this portion of the report was accepted.

The Reference Committee commended Doctor Neupert for his constant help in the direction of cooperation and assistance to the practice of medicine in the State of Wisconsin. Doctor Neupert outlined some of the proposed projects under consideration by the State Board of Health and clearly reaffirmed the role of the Board in health care in this state.

Dr. T. W. Tormey, Jr. reported on behalf of the State Board of Medical Examiners, clearly outlining problems concerning interns and residents now in Wisconsin hospitals who are graduates of foreign medical schools, as well as the other problems concerning the relationship of the practicing doctor in Wisconsin to his state government.

Mrs. A. J. Baumann, retiring President of the Woman's Auxiliary, personified the position which the doctor's wife so highly exemplifies in Wisconsin medicine. The Reference Committee reviewed with appreciation her "charming and interesting" report.

On motion of Doctor Gearhart, seconded by Dr. A. J. Sanfelippo, Milwaukee, carried, this portion of the report was accepted.

On motion of Doctor Gearhart, seconded by Doctor Sanfelippo, Milwaukee, carried, the report as a whole was adopted.

REMARKS OF THE PRESIDENT

President Harry E. Kasten: When I drove down to Milwaukee Saturday afternoon, my heart was very heavy indeed. My wife, who has helped me through many an ordeal and who has always been my staunchest supporter and who calls me "Harry", said, "Harry, don't worry. The House of Delegates, the physicians of Wisconsin, will never let Badger medicine down."

Tonight I am overwhelmed with a great sense of gratitude that you, the members of this House of Delegates, have demonstrated again, as you have on previous occasions, the fact that you are indeed medical statesmen.

When I relinquish the office of President to my and your good friend, Jerry Fons, I will be passing on to him what I think will be a great privilege that he will enjoy, that of having the great and singular distinction of becoming the President of the State Medical Society of Wisconsin, and that he will be able to go on with you fine people shoulder to shoulder in the struggle to maintain our proud profession of medicine on its high and honorable level. May God bless you for it.

ADJOURNMENT

The second session of the House adjourned at 9:00 p.m.

THIRD SESSION

Wednesday, May 7, 1958

The House of Delegates convened at 9:10 a.m., Dr. W. B. Hildebrand, Menasha, Speaker of the House, presiding.

REPORT OF THE COMMITTEE ON CREDENTIALS

The Committee on Credentials verified the registration of 36 delegates and 11 alternates entitled to vote at the third session of the House of Delegates. In addition, five alternate delegates and one councilor registered their attendance.

The Credentials Committee also reported that Dr. W. A. Gramowski, Stevens Point, had been duly appointed to act as delegate for the Portage County Medical Society and that Dr. R. E. Graber, Chippewa Falls, had been duly appointed to act as delegate for the Section on Public Health in the place of the regular delegates and alternates who were unable to attend.

On motion of Doctor Hirsch, Viroqua, seconded by Dr. E. A. Strakosch, carried, the attendance roll of delegates and alternate delegates totaling 47 was accepted as the official roll of the third session of the

House of Delegates to stand for the entire session.

The Credentials Committee also confirmed that Dr. M. L. Whalen, Bruce, had been duly appointed to act as delegate for the Rusk County Medical Society in place of the regular delegate and alternate who were unable to attend. In addition, 8 alternate delegates registered their attendance.

Subsequent registrations brought the total number of delegates and alternate delegates entitled to vote to 79.

AMERICAN MEDICAL EDUCATION FOUNDATION

Dr. A. H. Heidner, West Bend: We have been accorded the floor for a few minutes this morning to give you some information on the American Medical Education Foundation. We have been State Chairman of this organization for a number of years and haven't been doing a very good job, and so I introduced the subject to the Council. I have been given the privilege of having Mr. John Hedback, the Executive Secretary of the AMEF, talk to you for a few minutes.

The matter has not been discussed enough in this State, so I have asked Mr. Hedback to go back to the beginning and explain to you what the American Medical Education Foundation is and its importance in preserving medical education in this country.

Mr. John Hedback, Chicago: I am not here to present an impassioned appeal for the Foundation. I think all of you have heard something about it. I am interested primarily in giving you information on the Foundation, its progress and its background.

The Foundation was created in 1950 when the very critical problem of financing our medical schools was under consideration by not only leading medical educators but also by many people in business communities as well.

It was created at that time partly to forestall the interference of a paternal government in our medical education; it was also created to demonstrate the leadership of the medical profession in attacking this serious problem.

Since then it has been very vividly shown that with the leadership of the medical profession demonstrating the needs of the medical schools by reaching down into their own pockets and showing their concern for their schools, other sources of income for the medical schools would rally around.

In the past seven years there has been a very gratifying support from other sources. However, there is one very important effect that the Foundation is continuing to have an impact on. There is the real leadership that is demonstrated by the medical profession, but the funds from the AMEF have been a very important source of income to the deans of medical schools; in fact, the term "Deans' Fund" has often been referred to the Foundation's gift because of the completely unrestricted manner in which these gifts are given. The deans have been able to do so many of those little things that make the difference between carrying on a successful program during the year and being hamstrung.

For example, I mentioned the other afternoon one dean in Texas who told about his preclinical faculty. They were being paid as other members of the university were being paid, and were being offered much more attractive positions elsewhere. He was able to give them just $400 a year more in increased salary from the results of this Fund. The $400 was enough to show that he and the school were interested in their welfare. It was not enough to really pay them well, but when he told me about it he almost had tears in his eyes. He kept his faculty.

There are several points of information which I am sure have been brought to your attention but which you may not recall about the Foundation. One very important point in these days when people are so interested in the high cost of raising money is the fact that every gift you make to the Foundation goes in its entirety to the schools. The American Medical Association pays all the costs of administration and promotion of the Foundation.

The second important point is that you may earmark your gift for the school of your choice. We urge the doctor to give either to his school or to the Foundation, but to give.

Each month the schools send us a report of all gifts made by their physician alumni direct to the school. We in turn send them lists of all physicians who have given through the Foundation who earmarked their gift for the school. In this way we can coordinate the efforts of all who are appealing for medical education.

I would like to say here that I believe Wisconsin has been very generous, considering the fact that there has been no organized attempt to raise the level of giving to the Foundation here in Wisconsin. I would like to urge you that when you go back to your respective counties you tell them something about the Foundation, because the Foundation will be effective only if there are active people working in every county, interested in the very important continuing tuition that is your only opportunity to pay for the medical education that you receive throughout your lifetime.

Dr. A. H. Heidner, West Bend: I asked Mr. Hedback to talk to you on the whole subject. I would like to tell you just what Wisconsin has done.

Mr. Hedback was very kind when he said we have given liberally. Wisconsin has given liberally to its medical schools, chiefly represented by the drives for Marquette University funds.

In this whole picture throughout the country the need of the medical schools is about 10 million dollars. I am not going to go into what the total Fund is because we don't have time, but this comparatively shows that seven states have dues to raise of $10 or $20, and those are the states that are sending in the biggest contributions.

Illinois has a $20 raise in dues for the last few years, and last year they gave to the Foundation $199,000.

California has a $10 dues raise, and they gave $165,000.

Minnesota had an organized drive for funds, and they gave $36,000.

Indiana had an organized drive, and they gave $19,000.

Michigan gave $9,000.

Wisconsin gave $8,000.

In comparison to what we have given, I would like to tell you what we have received. First, Wisconsin physicians gave in 1956 the sum of $8,767 to the AMEF drive, but they gave $49,264 to the local schools. That may not be exactly a true figure, but that is what the alumni of Marquette and Wisconsin gave. So, some of this may be from outstate. In order to make the following picture not seem so grave, Wisconsin physicians gave approximately $49,000 to their local schools in 1957.

If some of this were routed through the AMEF it would help AMEF in its position with the industry, the American Foundation for Medical Education, because the contributors outside of the profession are always very much interested in what the medical profession is giving. If you are going to give to Marquette or Wisconsin or any other school, you can route your money through the AMEF and then you will be given full credit by your school in its drive for funds.

This is a rather sad story as far as I am concerned: I have never made any concerted drive in Wisconsin because we have had these other drives. First we had the Student Loan Fund, then we had the Wisconsin Charitable, Educational and Scientific Foundation, and now we have a drive for the Museum at Prairie du Chien.

I just didn't have the heart to put on another drive in Wisconsin while these other things were going on. We are going to try now to make some sort of contribution from the Charitable, Educational and Scientific Foundation this year, but we will also, through some other device, attempt to interest you people in giving individually.

There have been many rather large gifts, but on the whole very few people have contributed. If we could have a voluntary contribution of $10 by each man in each medical society it would help a lot, but I think we will have to guide that at the State level.

In 1956, seventy-nine physicians in Wisconsin gave $9,083. In 1957 more physicians gave; 126 physicians gave $8,687. However, when you analyze that, out of that $8,000 the Woman's Auxiliary gave $2,717. Those girls get out and work. They do it in devious ways, but, by George, they gave $2700! Another $2,000 was given by the Gunderson Foundation. That means $4,717.50 was not given by the doctors.

Out of our $8,000, which doesn't seem too small a figure, approximately 3,000 members gave $3,900, or approximately $1 each. We should have $10 from each doctor in the United States to give what the medical schools need. These funds are unrestricted.

Even if it is a state institution, most of their funds are unrestricted, and when they need things badly, in emergencies, and so on, every dean in the country feels that the money he gets from the Foundation is really a godsend. We get a lot of letters from people who don't give one penny.

I hope you will consider this seriously this year and will give to the Foundation.

Out of the $8,687 Marquette received in undesignated funds $6,850. Every four-year school in the country got $6,750. Earmarked funds for Marquette were $5,587. The University of Wisconsin got $6,850. Earmarked for Wisconsin was $5,230.89. Neither one of these are entirely from Wisconsin physicians. They are the alumni of each of these schools throughout the country that gave to the AMEF and earmarked their contributions for Marquette or Wisconsin. So, Marquette got $12,350, the University of Wisconsin got $12,080, and the two schools in Wisconsin together, therefore, received from AMEF $24,431.

We gave $8,000 and we got $24,000. To me it is a little disconcerting. I don't believe Wisconsin doctors are in a position where we want to accept charity for our own schools. We ought to at least pay our own way, and therefore I hope that when the opportunity comes along you will respond so that we will at least break even.

INTRODUCTION OF GUEST

Speaker Hildebrand introduced Dr. Walter Abbott, Des Moines, Iowa, President of the Iowa State Medical Society.

Dr. Walter Abbott, Des Moines: Gentlemen of Wisconsin, it is the desire of the Iowa State Medical Society to send our good wishes to you, and hope we can continue the happy cooperation in the future that we have enjoyed in the past. It is indeed a pleasure to be here.

RECOGNITION TO DOCTOR COMSTOCK

Dr. James C. Fox, La Crosse: It is indeed always an extreme pleasure for anyone to be asked to say a few words to the House of Delegates. Today it becomes not only a pleasure but a very profound honor for me to address you because of the nature of the duty I am called upon to perform.

Many times we get so embroiled in our insurance troubles, in the economics of our medical practices, that we sometimes put back in our memory the aptitude that makes us such a great and noble profession, and that is our service to mankind.

Today it is my extreme pleasure to present to you one who certainly personalizes all that is great in that attribute. This particular doctor for fifty-seven years, most of which have been spent in the hills and coulees of Western Wisconsin, has been serving humanity in a very great and noble manner. She has had an extreme interest in the affairs of medicine,

as is witnessed by her almost constant attendance at all county, district and State meetings. She has contributed much to the historical lore of our Society, having been here for such a period of time.

Today it is my extreme pleasure to present to you one who personalizes all that is great, all that is noble, all that is kind in the practice of medicine. Dr. Elizabeth Comstock, of Arcadia.

President Harry E. Kasten, Beloit: I, too, share with Doctor Fox what I consider to be a unique privilege in my considerable number of years of service to organized medicine in the State of Wisconsin. It is the privilege of recognizing the gentler and fairer sex at this time. It gives all of us a sort of feeling that teamwork is one of the very essential and most important phases of our work.

Your State Medical Society of Wisconsin, created in 1841, presents this resolution:

"Whereas, Dr. Elizabeth Comstock, of Arcadia, now practicing for the fifth-seventh year, holds an unusual record of participation in the affairs of the State Medical Society, including her regular attendance at the annual meetings and the circuit clinics, and

"Whereas, under her leadership, personal support and donations of family records and memorabilia constitute a unique contribution to the preservation of the medical history in the establishment of the Wisconsin Museum of Medical History; therefore, be it

"RESOLVED: That the officers and Councilors of the State Medical Society, by their signatures hereto, express to Doctor Comstock their highest regard and most sincere appreciation for her unstinting devotion to the finest traditions of the medical profession, in serving the public and in improving the profession."

Doctor Comstock, I am honored to present this resolution to you with our affection and love.

REPORT OF COMMITTEE ON NOMINATIONS

Speaker Hildebrand called upon Vice-Speaker Hirsch to assume the chair. Dr. C. J. Picard, Superior, Chairman of the Committee on Nominations presented the names of the following nominees for official positions in the State Medical Society:

For president-elect: Dr. W. B. Hildebrand, Menasha.

For speaker of the House: Dr. J. D. Leahy, Park Falls.

For vice-speaker of the House: Dr. L. H. Lokvam, Kenosha.

For delegate to the American Medical Association to succeed Dr. S. E. Gavin of Fond du Lac: Dr. L. O. Simenstad, Osceola.

For delegate to the American Medical Association to succeed Dr. D. H. Witte of Milwaukee: Dr. E. L. Bernhart, Milwaukee.

For alternate delegate to the American Medical Association to succeed Dr. L. O. Simenstad of Osceola: Dr. John M. Bell, Marinette.

For alternate delegate to the American Medical Association to succeed Dr. E. L. Bernhart of Milwaukee: Dr. J. M. Sullivan, Milwaukee.

For the site of the 1959 annual meeting: Milwaukee.

The Committee on Nominations also made the suggestion that in consideration of his services to the Society and to Wisconsin medicine in general, Dr. S. E. Gavin be accorded an appointment as delegate emeritus to the American Medical Association.

On motion of Doctor Picard, severally seconded, carried, the report of the Nominating Committee was accepted.

On motion of Dr. G. N. Gillett, Racine, severally seconded, carried, Dr. W. B. Hildebrand, Menasha, was unanimously elected to the office of President-Elect.

On motion of Dr. E. J. Nordby, Madison, seconded by Dr. P. B. Golden, Madison, carried, Dr. J. D. Leahy, Park Falls, was unanimously elected speaker of the House.

On motion of Dr. E. J. Nordby, Madison, seconded by Dr. P. B. Golden, Madison, carried, Dr. L. H. Lokvam, Kenosha, was unanimously elected to the office of vice-speaker of the House.

On motion of Dr. G. P. Schwei, Menasha, seconded by Dr. R. S. Gearhart, Madison, carried, Dr. L. O. Simenstad, Osceola, was unanimously elected as delegate to the American Medical Association. Term expires 1960.

On motion of Dr. A. J. Sanfelippo, Milwaukee, seconded by several, carried, Dr. E. L. Bernhart, Milwaukee, was unanimously elected as delegate to the American Medical Association. Term expires 1960.

On motion of Dr. J. G. Beck, Sturgeon Bay, seconded by Dr. P. B. Golden, Madison, carried, Dr. J. M. Bell, Marinette, was unanimously elected as alternate delegate to the American Medical Association. Term expires 1960.

On motion of Dr. A. J. Sanfelippo, Milwaukee, seconded by Dr. P. B. Golden, Madison, carried, Dr. J. M. Sullivan, Milwaukee, was unanimously elected alternate delegate to the American Medical Association. Term expires 1960.

On motion of Dr. E. J. Norby, seconded by Dr. P. B. Golden, Madison, carried, Milwaukee was selected as the site for the 1959 annual meeting.

ELECTION OF COUNCILORS

The House then proceeded to the election of Councilors, with the following results:

In the Third District, on nomination of Dr. P. B. Golden, Madison, seconded by Dr. E. J. Nordby, Madison, carried, Dr. N. A. Hill, Madison, was unanimously re-elected. Term expires 1961.

In the Fourth District, on nomination of Dr. L. L. Olson, Darlington, and on a motion by Dr. D. J. Taft, Richland Center, severally seconded, carried, Dr. E. M. Dessloch, Prairie du Chien, was unanimously re-elected. Term expires 1961.

In the Fifth District, on nomination by Dr. W. E. Acheson, Valders, and on a motion by Dr. D. M. Willson, Milwaukee, severally seconded, carried, Dr. P. B. Blanchard, Cedarburg, was unanimously elected. Term expires 1961.

In the Sixth District, on nomination by Dr. G. W. Carlson, Appleton, and on a motion by Dr. J. G. Beck, Sturgeon Bay, severally seconded, carried, Dr. H. J. Kief, Fond du Lac, was unanimously elected. Term expires 1961.

In the Twelfth District, on nomination by Dr. J. A. End, Milwaukee, and on a motion by Dr. E. J. Nordby, Madison, seconded by Dr. R. S. Gearhart, Madison, carried, Dr. J. P. Conway, Milwaukee, was unanimously re-elected. Term expires 1961.

INTRODUCTION OF GUEST

Speaker Hildebrand introduced Dr. H. S. Huxtable, Mineral Point, President of the Wisconsin State Dental Society, who extended his greetings to the Society.

ADJOURNMENT *SINE DIE*

On motion of Dr. E. A. Strakosch, Oshkosh, seconded by several, carried, the House of Delegates adjourned *sine die* at 10:50 a.m.

Attendance at House of Delegates May 5, 6, and 7, 1958

SOCIETY:	Sessions 1	2	3
Ashland–Bayfield–Iron—			
J. W. Prentice, Ashland	o	o	o
J. M. Jauquet, Ashland	x	x	o
Barron–Washburn–Sawyer–Burnett—			
H. M. Templeton, Barron	x	x	x
W. B. Rydell, Rice Lake	o	o	o
Brown—			
L. C. Miller, Green Bay	x	x	x
J. L. Ford, Green Bay	o	o	o
R. M. Waldkirch, De Pere	x	x	x
S. L. Griggs, Green Bay	o	o	o
Calumet—			
J. A. Knauf, Stockbridge	o	o	o
A. C. Engel, New Holstein	x	x	x
Chippewa—			
J. J. Sazama, Chippewa Falls	x	x	x
C. A. Kemper, Chippewa Falls	o	o	o
Clark—			
M. V. Overman, Neillsville	x	x	x
J. W. Koch, Colby	x	x	o
Columbia–Marquette–Adams—			
R. F. Inman, Montello	x	x	x
R. T. Cooney, Portage	o	x	x
Crawford—			
V. C. Epley, Prairie du Chien	x	x	x
T. F. Farrell, Prairie du Chien	o	o	o
Dane—			
J. R. Steeper, Madison	x	x	x
R. A. Straughn, Madison	x	x	x
M. T. Morrison, Mount Horeb	x	x	x
V. W. Nordholm, Stoughton	o	o	o
R. S. Gearhart, Madison	x	x	x
J. F. Land, Madison	o	o	o
C. W. Stoops, Madison	x	x	x
R. P. Sinaiko, Madison	x	o	o
G. C. Hank, Madison	x	x	x
R. J. Hennen, Madison	o	o	x
E. J. Nordby, Madison	x	x	x
H. M. Suckle, Madison	o	o	o
P. B. Golden, Madison	x	x	x
A. P. Schoenenberger, Madison	o	x	x
Dodge—			
L. W. Schrank, Waupun	x	x	x
H. G. Bayley, Beaver Dam	x	o	x
Door–Kewaunee—			
J. G. Beck, Sturgeon Bay	x	x	x
C. W. Stiehl, Algoma	x	o	o
Douglas—			
C. J. Picard, Superior	x	x	x
H. A. Sincock, Superior	o	o	o
Eau Claire–Dunn–Pepin—			
R. M. Lotz, Eau Claire	x	x	x
I. L. Blose, Durand	x	x	x
O. G. Moland, Augusta	x	x	x
R. C. Brown, Eau Claire	o	o	o
Fond du Lac—			
H. J. Kief, Fond du Lac	x	x	x
D. J. Twohig, Jr., Fond du Lac	o	x	x
Forest—			
E. F. Castaldo, Laona	o	x	x
B. S. Rathert, Crandon	o	o	o
Grant—			
E. C. Howell, Fennimore	x	x	x
M. W. Randall, Boscobel	o	x	x
Green—			
R. G. Zach, Monroe	x	x	x
W. E. Hein, Brodhead	o	o	o
L. G. Kindschi, Monroe (elected alternate May sessions only)	x	o	o
Green Lake–Waushara—			
V. J. Taugher, Berlin	o	o	o
R. D. Wichmann, Wild Rose	x	x	o
Iowa—			
W. P. Hamilton, Dodgeville	o	x	o
W. D. Hamlin, Mineral Point	x	o	o
Jefferson—			
R. W. Quandt, Jefferson	x	x	o
H. G. E. Mallow, Fort Atkinson	o	o	x
Juneau—			
V. M. Griffin, Mauston	o	o	o
J. H. Vedner, Mauston	o	o	o
Kenosha—			
H. L. Schwartz, Kenosha	x	x	x
R. W. Ashley, Kenosha	o	x	o
La Crosse—			
J. J. Satory, La Crosse	x	x	x
E. L. Perry, La Crosse	o	o	o
J. P. McCann, La Crosse	x	x	x
J. R. Richter, La Crosse	o	o	o

Indented names are those of alternates.

Lafayette—

L. L. Olson, Darlington	x	x	x
D. J. Garland, Shullsburg	o	o	o

Langlade—

B. W. Beattie, Antigo	x	x	x
W. P. Curran, Antigo	x	x	o

Lincoln—

D. F. Jarvis, Tomahawk	o	o	o
W. E. Braun, Merrill	o	o	o

Manitowoc—

W. E. Acheson, Valders	x	x	x
N. A. Borner, Manitowoc	o	o	o

Marathon—

D. M. Green, Wausau	x	x	o
E. P. Ludwig, Wausau	x	x	x

Marinette-Florence—

C. E. Koepp, Marinette	x	x	x
J. W. Boren, Jr., Marinette	o	x	x

Milwaukee—

A. J. Baumann, Milwaukee	x	x	x
F. A. Ross, Milwaukee	x	x	o
B. J. Brewer, Milwaukee	x	x	x
H. C. High, Jr., Milwaukee	x	x	o
R. T. McCarty, Milwaukee	x	x	x
D. W. Calvy, Milwaukee	o	x	o
R. F. Purtell, Milwaukee	x	x	x
J. J. O'Hara, Milwaukee	o	o	o
S. L. Chojnacki, Milwaukee	x	x	o
C. M. Schroeder, Milwaukee	x	x	x
A. J. Sanfelippo, Milwaukee	x	x	x
E. A. Habeck, Milwaukee	o	o	o
M. C. F. Lindert, Milwaukee	o	x	o
V. L. Baker, Milwaukee	x	x	o
D. M. Willson, Milwaukee	x	x	x
S. E Zawodny, Milwaukee	o	x	x
E. M. End, Wauwatosa	x	x	x
H. F. Twelmeyer, Milwaukee	x	x	o
S. W. Hollenbeck, Milwaukee	x	x	x
P. F. Hausmann, Milwaukee	o	o	o
P. E. Oberbreckling, Milwaukee	x	x	x
A. A. Presti, Milwaukee	o	o	o
F. E Drew, Milwaukee	x	x	o
R. E Cailan, Milwaukee	o	o	o
W J. Houghton, Milwaukee	x	x	o
G. J. Bergmann, Milwaukee	x	x	x
G. W. Hilliard, Jr., Milwaukee	x	x	x
W. J. Conen, Milwaukee	x	o	o
J. F. Cary, Milwaukee	o	x	x
E J. Schmidt, Milwaukee	x	x	o
J. M. Sullivan, Milwaukee	x	x	o
R. H. Lillie, Milwaukee	o	o	o
R. W. Mann, Milwaukee	x	x	x
D. M. Ruch, Milwaukee	x	x	x
H. J. Lee, Milwaukee	o	o	o
J. M. Beffel, Milwaukee	x	x	o
G. E. Collentine, Milwaukee	x	x	x
R. A. Nimz, Milwaukee	x	x	o
E G. Collins, West Allis	x	x	o
R. H. Frederick, West Allis	x	x	o
N. J. Wegmann, Milwaukee	x	x	x
W. L. Coffey, Milwaukee	x	x	x

Monroe—

D. C. Beebe, Sparta	o	x	x
J. S. Allen, Norwalk	x	o	o

Oconto—

H. A. Aageson, Oconto	x	x	x
G. R. Sandgren, Suring	o	o	o

Oneida-Vilas—

Marvin Wright, Rhinelander	x	x	x
I. E. Schick, Rhinelander	o	o	o

Outagamie—

G. W. Carlson, Appleton	x	x	x
H. T. Gross, Appleton	o	x	o

Pierce-St. Croix—

P. H. Gutzler, River Falls	x	x	x
O. H. Epley, New Richmond	x	x	o

Polk—

L. O. Simenstad, Osceola	x	x	x
R. M. Moore, Frederic	o	o	o

Portage—

F. E. Gehin, Stevens Point	o	o	o
R. H. Slater, Stevens Point	o	o	o
W. A. Gramowski, Stevens Point	x	x	x

Price-Taylor—

J. D. Leahy, Park Falls	x	x	x
W. E. Niebauer, Phillips	o	o	o

Racine—

Gordon Schulz, Union Grove	o	x	x
F. J. Scheible, Racine	o	x	o
R. W. Kreul, Racine	x	x	x
L. E. Fazen, Jr., Racine	o	o	o

Richland—

R. E. Housner, Richland Center	x	x	o
D. J. Taft, Richland Center	o	o	x

Rock—

W. S. Freeman, Beloit	x	x	o
T. C. Sweeney, Beloit	o	x	x
M. D. Davis, Milton	x	x	o
H. M. Snodgrass	o	o	o

Rusk—

H. F. Pagel, Ladysmith	o	o	o
J. E. Murphy, Ladysmith	o	o	o
M. L. Whalen, Bruce	o	x	x

Sauk—

C. R. Pearson, Baraboo	x	x	x
J. J. Rouse, Reedsburg	x	x	x

Shawano—

H. C Marsh, Shawano	x	x	x
D. A. Jeffries, Shawano	o	o	o

Sheboygan—

P. B. Mason, Sheboygan	x	x	o
F A. Nause, Sheboygan	o	x	x

Trempealeau-Jackson-Buffalo—

B. C. Dockendorff, Arcadia	x	x	x
E. P. Rohde, Galesville	x	x	x

Vernon—

T. E. Boston, Hillsboro	x	x	x
P. T. Bland, Westby	o	x	o

Walworth—

E. D. Sorenson, Elkhorn	x	x	x
E. D Hudson, Lake Geneva	o	o	o

Washington-Ozaukee—

P. B. Blanchard, Cedarburg	x	x	x
W. A. Nielsen, West Bend	x	o	x

Waukesha—

Joseph Bartos, Waukesha	x	x	x
Aaron Sweed, Waukesha	o	x	o

Waupaca—

M. O. Boudry, Waupaca	o	x	x
W. R. McInnis, Marion	o	o	o

Winnebago—

George Schwei, Menasha	x	x	x
David Regan, Neenah	o	o	o
E. A. Strakosch, Oshkosh	x	x	x
W. V. Hahn, Oshkosh	x	x	o

Wood—

R. W. Mason, Marshfield	x	x	x
E. C. Glenn, Wisconsin Rapids	x	x	x

SECTION:

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T. J. Nereim, Madison	x	o	x
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Internal Medicine—

L. J. Kurten, Racine	x	x	x
R. L. Gilbert, La Crosse	o	o	o

Neurology and Psychiatry—

David Cleveland, Milwaukee	o	x	x
Edward Burns, Madison	o	o	o

Obstetrics and Gynecology—

Elizabeth Steffen, Racine	x	x	o
R. T. Flynn, Milwaukee	o	o	o

Ophthalmology and Otolaryngology—

H. C. High, Jr., Milwaukee	x	x	o
George Nadeau, Green Bay	x	x	x

Orthopedics—

D. W. McCormick, Fond du Lac	o	o	o
F. G. Gaenslen, Milwaukee	x	x	o

Pathology—

Gorton Ritchie, Milwaukee	x	x	x
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Pediatrics—

S. E. Kohn, Milwaukee	o	o	o
J. R. Schroder, Janesville	o	o	o

Public Health—

C. K. Kincaid, Madison	x	x	o
E. E. Bertolaet, West Allis	x	o	o
R. E. Graber, Chippewa Falls (3rd session only)			x

Radiology—

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Urology—

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R. S. Irwin, Milwaukee	o	o	o
J. D. Silbar, Milwaukee	x	x	x

LET THESE GUIDES HELP YOU

The following guides and manuals have been prepared at the direction of a number of councils, commissions, divisions, and committees of the State Medical Society to be of direct personal assistance to the physician or his county society. Each is available without cost upon request to the State Medical Society office, Box 1109, Madison 1, Wisconsin:

1. **Interprofessional Code**—An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.
2. **Civil Defense Manual for Mobile Medical Team Personnel**—An explanation of the Wisconsin program for civil defense and the role of mobile medical teams in that program.
3. **Code of Necropsy Procedure**—A guide to physicians, hospitals, and funeral directors in the performance of necropsies.
4. **Guide for the Development of a Local or Regional Rheumatic Fever Program**—Recommendations for a model rheumatic fever program emphasizing the convalescent home, diagnostic and follow-up clinics, and a home-service plan.
5. **Hearing Conservation Programs for Wisconsin Industries**—Some recommended standards and principles for providing a hearing conservation program in industry.
6. **Occupational Health, A Guide for Medical and Nursing Personnel**—General principles and suggested plans for an industrial health program, with emphasis on written procedure for nurses.
7. **Medical Care of Migrant Agricultural Workers**—A guide to physicians and operators of licensed industrial camps in Wisconsin on the formulation of a local plan for the care of migrant workers.
8. **Minimum Standards of Medical Care for County Hospitals**—A guide to physicians and county asylum superintendents concerning medical care for patients in county hospitals.
9. **Participation by Physicians in Radio and Television Programs**—A guide to physicians and county medical societies for their presentation of or participation in radio and television programs.
10. **Planning Your Career as a Medical Associate**—A brochure to acquaint young people with the careers open to them in fields related to medicine.
11. **School Health Examinations**—A guide for physicians and school authorities in establishing a program of school health examinations.
12. **School Vision Screening Program**—An outline to facilitate the development of a program to detect significant visual defects among school children.
13. **Statement of Objectives of the Wisconsin Plan and Conditions for Participation by Private Carriers**—A list of the objectives of the State Medical Society in devising the Wisconsin Plan and the conditions under which insurance carriers may participate in that plan.
14. **The Income Tax for Wisconsin Physicians**—A brochure, newly revised, containing a review of the state and federal income tax laws as they apply to the physicians of Wisconsin.
15. **The Doctor's Role in Adoptions**—A reprint of three *Wisconsin Medical Journal* articles issued by the Division for Children and Youth, State Department of Public Welfare, Madison.

Section on Medical History

The State Medical Society's Section on Medical History came into possession of a Lincoln letter this past summer.

Dr. Elizabeth Comstock, of Arcadia, a member of the Society's "50 Year Club," sent a packet of material to Madison. She was cited by the Society's House of Delegates last May for her great interest in medical history. The packet included many items which had belonged to her uncle, Maj. Gen. Cyrus B. Comstock, who served with distinction in the Civil War.

Abraham Lincoln's signature was written at the end of a letter penned by a minister being held a Union prisoner. The president asked that the prisoner's plea be given consideration.

Addressed to Rob Stone, the Great Emancipator's note read:

"Please show (the minister's letter) to Wm. Bayard Smith.

"Will Gen. Grant have this case investigated and do as much as he can deem consistent with the public interest.—A. LINCOLN."

The prisoner, Edmund C. Murdaugh, wrote from Ft. Powhatan, James River, on August 17, 1864. His letter stated that he was being held unjustly, and had been charged with the crime of cutting telegraph wires. He said:

"Conscious of my innocence, were I alone in the world I might be better content to abide my time. But for the sake of the wife of my early youth and the helpless babies whom God has given me I must ask if you can do anything to procure my release. . ."

A second letter, this one puzzling and tantalizing in nature, dated November 10, 1866, read:

"I am in receipt of your letter of Oct. 31. Have read and destroyed it.—SHERIDAN."

The material also included a $2 bill signed by Doctor Comstock's great-greatgrandfather, Adam Comstock. It was put out by the State of Rhode Island and Providence Plantation. It pledged to pay "Two Spanish milled dollars by the 31st day of December, 1786."

Another item was a ticket to the impeachment of President Andrew Jackson.

* * *

Dr. A. J. Wiesender, of Berlin, who has been practicing medicine for more than 40 years, recently sent the State Historical Society a fee bill dated March, 1844.

The fee bill, carrying the names of 11 Milwaukee physicians, states:

"Resolved, that we will honorably and in good faith maintain the rates of our fee bill and adhere in practice to its specific items as a compensation for our services."

The physicians:

Drs. J. B. Dousman, W. L. Bean, J. K. Bartlett, Hubbel Loomis, E. S. Marsh, J. S. Hewitt, E. B. Wolcott, Francis Hubschmann, D. H. Shumway, F. Kalckhoff and Frederick August Luning.

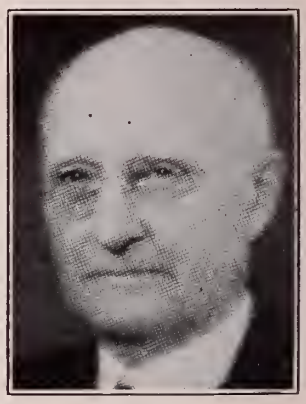
In all instances the city is spelled "Milwaukie" on the schedule poster.

Fees range from 50 cents, for venesection, extracting two teeth, to $50 to $100, for amputating hip and shoulder joints. Verbal advice is listed at $1, letter of advice $2 to $5, cupping $1, gonorrhea (in advance) $5, syphilis (in advance) $10, cutting fraenum linguae $1 and trephining $30. Fourteen listings were made for office calls and visits to patients, with rates varying for service, distance traveled and type of ailment, from 50 cents to $10. These also included obstetrical care.

On heavy cardboard, the fee bill undoubtedly was posted on the office walls of the physicians who joined together to set the rates.

* * *

Dr. James Daniel Madison, Milwaukee, who was made a life member of the State Medical Society in 1954, also published that year a book of his own historical notes pertaining to his practice and his family. He named it, "*Recollections of Vanished Years*," and it was published in a limited edition.



Doctor Madison

His early years in West Point (Columbia County) and Mazomanie (Dane County) were related, as were his years of education at the University of Wisconsin and Johns Hopkins University, where he received his medical degree in 1898.

Doctor Madison had rich praise for two teachers, Edward A. Birge, of Wisconsin, and Dr. William Osler, of the Baltimore school. Of Osler he said:

"One of the finest teachers and physicians anywhere . . . At the time of his death, he probably was the greatest figure in the medical world, the best known, the most influential, the most beloved, the most inspiring in clinical teaching, the most outstanding in such fields as children's diseases, in neurology, studies of the blood and malaria, diseases of the heart. He added knowledge to every condition or disease he uncovered."

After graduation and internship, Doctor Madison was appointed head of the women's department of Danvers Insane Hospital in Massachusetts, holding this post until 1902. That year he came to Milwaukee and specialized in internal medicine until his retirement.

STACKS

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REFERENCES: (1) Wise, R. I.: *J.A.M.A.* 166:1178, 1958. (2) Brown, J. W.: *J.A.M.A.* 166:1185, 1958. (3) Caswell, H. T., *et al.*: *Surg., Gynec. & Obst.* 106:1, 1958. (4) Godfrey, M. E., & Smith, I. M.: *J.A.M.A.* 166:1197, 1958. (5) Waisbren, B. A.: *Wisconsin M. J.* 57:89, 1958. (6) Royer, A., in Welch, H., & Marti-Ibañez, E: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 783. (7) Markham, N. P., & Shott, H. C. W.: *New Zealand M. J.* 57:55, 1958. (8) Blair, J. E., & Carr, M.: *J.A.M.A.* 166:1192, 1958. (9) Horan, J. M.: *Pediatrics* 19:36, 1957. (10) Rawls, G. H.: *Am. Surgeon* 23:1030, 1957. (11) Sarason, E. L., & Bauman, S.: *Surg., Gynec. & Obst.* 105:224, 1957. (12) James, U.: *Brit. J. Clin. Pract.* 11:801, 1957. (13) Turnbull, R. B., Jr.: *J.A.M.A.* 164:756, 1957. (14) Ross, S.; Puig, J. R., & Zaremba, E. A., in Welch, H., & Marti-Ibañez, E: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 803. (15) Leachman, R., & Yow, E. M., in Conn, H. E: Current Therapy 1958, W. B. Saunders Company, Philadelphia, 1958, p. 51.

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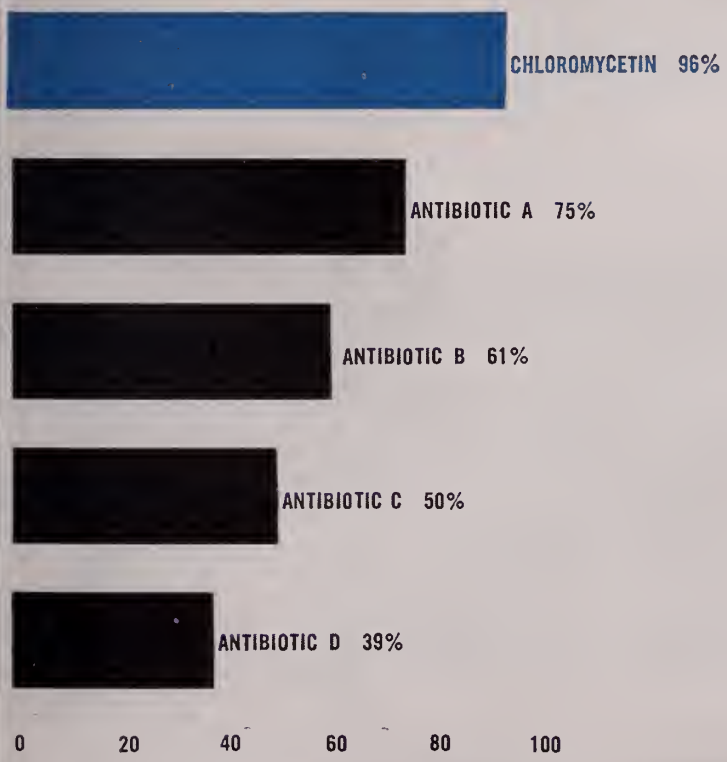

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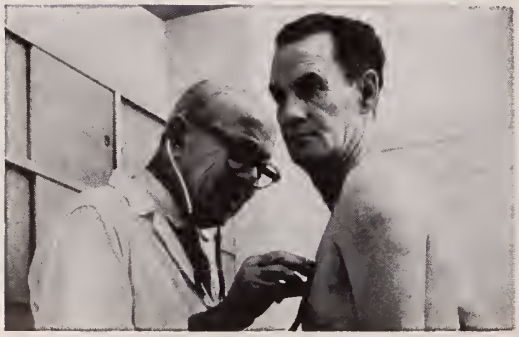

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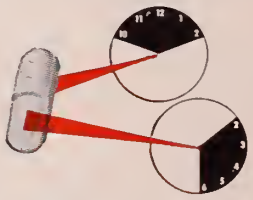

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(1) Hagedorn, A. B.: Proc. Staff Meet. Mayo Clin. 32 705 (Dec. 11) 1957.
(2) Best, W. R.; Louis, J., and Limarzi, L. R.: M. Clin. North America (Jan.) 1958, p. 3.

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1 Grieble, H.G., and Jackson, G.G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958

2. Editorial: *New England J. Med.* 258:48-49, 1958.

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The film is described as a vivid account of what is possibly the most dramatic and most taxing emergency confronting a surgeon. "Just Four Minutes" refers to the brief time during which a heart that has stopped beating must be revitalized, if the body's vital organs are not to be seriously impaired. The movie pictures each step in the accepted procedure for dealing with cardiac arrest, highlighting manual massage of the heart, direct injection of drugs and use of a "pacemaker."

Cooperating in the film's production were the Grasslands Hospital in Valhalla, New York, and the American Heart Association.

American Registry of Doctor's Nurses

National recognition of the doctor's nurse is being carried out in a newly formed organization known as THE AMERICAN REGISTRY OF DOCTOR'S NURSES, whose aims and functions were outlined in an article in *GP*, published by the American Academy of General Practice, October, 1958, issue.

Because of the shortage of registered nurses, the individual physician's office has undertaken a program of training, education and guidance to fill this lack of skilled help. The result has been a voluminous semi-skilled, but highly specialized group without national recognition.

Membership is open to all persons who have had experience in a doctor's office or clinic. Only nurses employed by doctors of medicine who are members in good standing of American Medical Association will be considered.

Note!

The Twenty-fifth Annual Meeting, Silver Anniversary, of the American College of Chest Physicians will be held at Atlantic City, New Jersey, on June 3–7, 1959.

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Extensive clinical tests show that when the diet contains an adequate amount of Mazola Corn Oil, serum cholesterol levels tend to be normal . . . high blood cholesterol levels are lowered, normal levels maintained.

Fortunately for both physician and patient, Mazola Corn Oil is not only rich in unsaturated fatty acids, it is also a delicious food. It becomes an enjoyable and normal part of the patient's daily meals—no complicated or special diet is required.

Here is a therapy easy for you to prescribe, easy and pleasant for your patients to follow.

Nutritional authorities generally recommend that fats should provide no more than 30% of the total calories. In cholesterol-lowering diets from one-third to one-half of these fats should be unsaturated, such as in Mazola Corn Oil.

IN COOKING OR SALADS

Mazola Corn Oil is a superlative cooking oil as well as a delicious salad oil. Adequate amounts can be eaten daily—in a wide variety of salad dressings and in a great number of fried and baked foods.

MOST EFFECTIVE

Pure, clear, bland and odorless. Mazola Corn Oil is stable and dependable, providing the full measure of cholesterol-lowering unsaturated fatty acids characteristic of corn oil.

ECONOMICAL

Mazola Corn Oil is sold in grocery stores throughout the country, is available everywhere. Its comparatively low cost makes it as economical as it is effective.

CORN PRODUCTS
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MAZOLA* CORN OIL is a rich source of unsaturated fatty acids. It can form a regular part of the diet without major changes in eating habits to provide an effective unsaturated oil as a part of the daily meals.

EACH TABLESPOONFUL OF MAZOLA CORN OIL PROVIDES NOT LESS THAN:

Linoleic Acid	7.4 Gm.
Sitosterols	130 mg.
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TYPICAL AMOUNTS PER DIET

For a 3600 calorie diet	3 tablespoonsful
For a 3000 calorie diet	2.5 tablespoonsful
For a 2000 calorie diet	1.5 tablespoonsful

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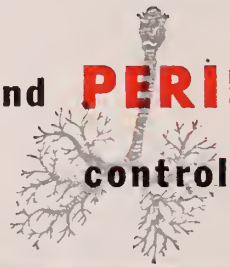

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plus Antihistaminic and Expectorant Action

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Each teaspoonful (4 cc.) contains:

Neo-Synephrine® hydrochloride	5.0	mg.
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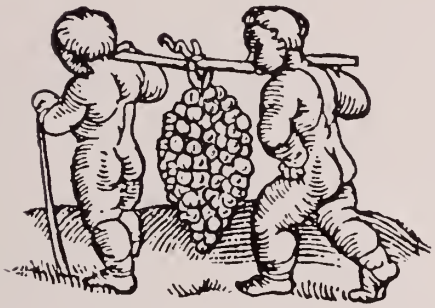
Dihydrocodeinone bitartrate	1.33	mg.
Potassium guaiacol sulfonate	70.0	mg.
Ammonium chloride	70.0	mg.
Menthol	1.0	mg.
Chloroform	0.02	cc.
Alcohol	8%	

Bottles of 16 fl. oz.

EXEMPT NARCOTIC

why wine in digestive disorders?



Although the effects of wine on the digestive system have been discussed for centuries, it has been only in recent years that many of its physiological attributes have been determined.

WINE AND THE SALIVARY GLANDS—The increase in salivary flow following a moderate intake of wine is apparent almost immediately,[1] such increase being attributed to direct sensitization of secretory nerve endings.[2]

WINE AND GASTRIC SECRETION—With a pH averaging 3.2, wine resembles gastric juice more closely than does any other natural beverage. Its tannins, organic acids and salts of these acids serve as buffering agents to maintain this pH. Relatively low in content of alcohol, table wine has been found to stimulate gastric secretion and induce production of gastric juice high in hydrochloric acid, sodium chloride, rennin and pepsin.[3]

WINE AND THE DIGESTIVE TRACT—With its low concentration of alcohol, wine in moderate consumption has been found to induce a marked increase in biliary flow.[4] This, together with increased function of pancreatic enzymes, may thus encourage better digestion of fatty foods.

THEREFORE—IN THE TREATMENT OF DIGESTIVE DISORDERS—Wine is being widely recommended in the treatment of anorexia, hypochlorhydria without gastritis, mucous colitis, spastic constipation and diarrhea, and in digestive disorders stemming from emotional tension and anxiety.

These and other modern ℞ uses for wine are discussed in the brochure "Uses of Wine in Medical Practice." For your free copy write—Wine Advisory Board, 717 Market Street, San Francisco 3, California.

1. Winsor, A. L. and Strangin, E. I.: J. Exper. Psychol. 16:589 (1933).
2. Beazell, J. M., and Ivy, A. C.: Quart. J. Studies on Alc. 1:45 (1940).
3. Faray, G., and Weissenbach, R. J.: Hôpital 25:306 (1937).
4. Okada, S.: J. Physiol. 49:457 (1915).

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CLINICAL BRIEFS FOR MODERN PRACTICE

"EMPTYING" OF GALLBLADDER AFTER FATTY MEAL*

*Adapted from Wright, S.: Applied Physiology, ed. 8, London, Oxford University Press, 1947, p. 734.

What's wrong with the term "emptying of the gallbladder"?

The gallbladder discharges bile by fractional evacuation. It is not emptied completely at any one time even following a fatty meal.

Source—Lichtman, S. S.: Diseases of the Liver, Gallbladder and Bile Ducts, ed. 3, Philadelphia, Lea & Febiger, 1953, vol. 2, p. 1177.

routine physiologic support for "sluggish" older patients

DECHOLIN® one tablet t.i.d.
therapeutic bile

increases bile flow and gallbladder function—combats bile stasis and concentration . . . helps thin gallbladder contents.

corrects constipation without catharsis—prevents colonic dehydration and hard stools . . . provides effective physiologic stimulant.

DECHOLIN tablets (dehydrocholic acid, AMES) 3¾ gr. Bottles of 100 and 500.

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you were to examine these patients

could you detect the asthmatic on Medrol*?

Probably not. Not without a history.

First, because he's more than likely symptom-free.

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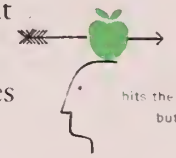
Even your practiced clinical eye would find it difficult to spot someone else's Medrol patient.

But in your own patients, you could see the advantages of Medrol right away. Why not try it?



Medrol hits the **disease,** but spares the **patient**

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The *cough control* provided by homarylamine (a non-narcotic antitussive) approximates that of codeine.

Three antibiotics (bacitracin, tyrothricin, neomycin) act in combination against a wide variety of pathogens—with little danger of side reactions.

The anesthetic-analgesic effect of benzocaine brings *soothing relief* to inflamed tissues of mouth and throat.

PENTAZETS now extend the therapeutic usefulness of convenient troche medication. Each pleasant-tasting PENTAZETS troche acts promptly against the most bothersome aspects of mouth and throat irritations.

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Dosage: Three to 5 troches daily for 3 to 5 days.
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both cause and fear of
ANGINA ATTACKS

proven safety for long-term use

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NEW DOVETAILED THERAPY COMBINES IN ONE TABLET

prolonged relief from anxiety and tension with **MILTOWN®** — The *original* meprobamate, discovered and introduced by Wallace Laboratories

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sustained coronary vasodilation with **PETN** — pentaerythritol tetranitrate a leading, long-acting nitrate

"In diagnosis and treatment [of cardiovascular diseases] . . . the physician must deal with both the emotional and physical components of the problem simultaneously."[1]

The addition of Miltown to PETN, as in Miltrate,"...appears to be more effective than [PETN] alone in the control of coronary insufficiency and angina pectoris."[2]

Miltrate is recommended *for prevention* of angina attacks, *not for relief* of acute attacks.

Supplied: Bottles of 50 tablets.
Each tablet contains: 200 mg. Miltown + 10 mg. pentaerythritol tetranitrate.
Usual dosage: 1 or 2 tablets q.i.d. *before meals* and at bedtime.
Dosage should be individualized. *For clinical supply and literature, write Dept. 60C*

1. *Friedlander, H. S.: The role of ataraxics in cardiology. Am. J. Card.* **1**:395, *March 1958.*
2. *Shapiro, S.: Observations on the use of meprobamate in cardiovascular disorders. Angiology* **8**:504, *Dec. 1957.*

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Wanted!

Old Photos of Physicians Driving Ancient Cars

The Illinois State Medical Society is preparing an exhibit centered around an *Illinois Medical Journal* article which told of the role of physicians in the development of the automobile in the United States at the turn of the century.

To help illustrate this exhibit, the Society will appreciate the loan of old photographs showing physicians at the wheels of cars of 1900–1910 vintage. Scenes showing difficulties on the road, or poor highway conditions, are especially desired. Enlargements will be made of these photographs and the originals returned undamaged.

Photographs should be accompanied by a memo giving the name and town of the physician, whether living or deceased, and the make and year of the automobile. They should be sent to Mr. John A. Mirt, Illinois State Medical Society, 185 North Wabash Avenue, Chicago 1.

SPECIALISTS AND GENERAL PRACTITIONERS

Available through Placement Service

The Placement Service of the State Medical Society has registered with it a number of specialists in various fields as well as general practitioners. Contact the Placement Service by writing Box 1109, Madison, Wisconsin.

Announcing **THE TWENTY-SECOND ANNUAL MEETING OF**

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Conference Headquarters—Roosevelt Hotel—March 2, 3, 4, 5, 1959

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ANESTHESIOLOGY

Otto H. Janton, M. D., Philadelphia, Penn.
CARDIOLOGY

Carl T. Nelson, M. D., New York, N. Y.
DERMATOLOGY

Clifford I. Barborka, M. D., Chicago, Ill.
GASTROENTEROLOGY

Malcom E. Phelps, M. D., El Reno, Okla.
GENERAL PRACTICE

Keith P. Russell, M. D., Los Angeles, Calif
GYNECOLOGY

William Dameshek, M. D., Boston, Mass.
INTERNAL MEDICINE

Howard P. Rome, M. D., Rochester, Minn.
NEUROPSYCHIATRY

R. Gordon Douglas, M. D., New York, N. Y
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Maynard C. Wheeler, M.D., New York, N. Y
OPHTHALMOLOGY

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Lectures, symposia, clinicopathologic conferences, round-table luncheons, medical motion pictures and technical exhibits.
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THE CLINICAL TOUR TO MEXICO CITY, CUERNAVACA, TAXCO, ACAPULCO AND SAN JOSE PURUA
Leaving March 6 from New Orleans and returning March 21, 1959.

For information concerning the Assembly meeting and the tour write Secretary, Room 103, 1430 Tulane Avenue, New Orleans 12, La.

83% MAJOR (Grade I and II) IMPROVEMENT*

in Rheumatoid Arthritis

*Using combined drug therapy with **PLAQUENIL®** or Aralen® as maintenance therapy. With Plaquenil or Aralen alone 62% grade I and II improvement. (Scherbel, A.L.; Harrison, J.W., and Atdjian, Martin: Cleveland Clin. Quart. 25:95, April, 1958. Report on 805 patients with rheumatoid arthritis or related diseases.)

Reasons for Failure:

1. Treatment discontinued too soon (percentage of patients improved increases substantially after first six months).
2. Patients in relapse after prolonged steroid therapy are resistant to Plaquenil or Aralen treatment for several months.

Plaquenil sulfate is supplied in tablets of 200 mg., bottles of 100.

Dose: Initial — 400 to 600 mg. (2 or 3 tablets) daily.
Maintenance — 200 to 400 mg. (1 or 2 tablets) daily.

Write for Booklet.

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nd of hydroxychloroquine), trademarks reg. U.S. Pat. Off.

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PRONOUNCED TAY-O

(brand of triacetyloleandomycin with glucosamine)

Capsules / Oral Suspension

designed for effective control of common gram-positive infections

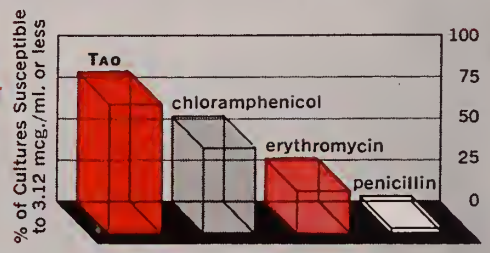
effective . . .

CLINICAL RESULTS	adults	children	all Staph infections
Cured	172 (80%)	148 (89%)	71 (88%)
Improved	28 (13%)	8 (5%)	7 (9%)
Failure	17 (7%)	11 (6%)	3 (3%)

Types of infecting organisms: The majority of identified etiologic microorganisms were Staph. aureus and Staph. albus. TAO has its greatest usefulness against organisms such as: staphylococci (including strains resistant to other antibiotics), streptococci (beta-hemolytic strains, alpha-hemolytic strains and enterococci), pneumococci, gonococci, Hemophilus influenzae.

even against resistant staph[1,2] . . .

Per cent of "antibiotic-resistant" epidemic staphylococci cultures susceptible to TAO, erythromycin, penicillin and chloramphenicol.[1]



well tolerated . . .

REACTIONS:

(a) adults	(b) children
Total—9.2% (20 out of 217)	Total—0.6% (1 out of 167)
Skin rash—1.4% (3 out of 217)	Skin rash—none
Gastrointestinal—7.8% (17 out of 217)	Gastrointestinal—0.6% (1 out of 167)

There was complete freedom from adverse reactions in 94.5% of all patients. Side effects in the other 5.5% were usually mild and seldom required discontinuance of therapy.

plus . . . stability in gastric acid • rapid, high and sustained blood levels • high urinary concentrations • outstanding palatability in a liquid preparation

Dosage and Administration: Dosage varies according to the severity of the infection. For adults, the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. For children 8 months to 8 years of age, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective. Since TAO is therapeutically stable in gastric acid, it may be administered at any time, without regard to meals.

Supplied: TAO Capsules—250 mg. and 125 mg.; bottles of 60. TAO for Oral Suspension—1.5 Gm.; 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

References: 1. English, A. R., and Fink, F. C.: Antibiotics & Chemother. (Aug.) 1958. 2. English, A. R., and McBride, T. J.: Antibiotics & Chemother. (Aug.) 1958. 3. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy (Aug.) 1958. 4. Celmer, W. D., et al.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 476.

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nasal and paranasal congestion and control secondary invaders

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Wide-Spectrum Action. Secondary bacterial infections, which are always a threat in upper respiratory involvement, are forestalled by the wide-spectrum effectiveness of triple sulfonamides. This added antibacterial protection makes Trisulfaminic highly useful in treating the debilitated patient who is prone to lingering or frequently recurring colds.

Trisulfaminic *tablets and suspension*

TRIAMINIC PLUS TRIPLE SULFAS

Each Tablet and each 5 ml. teaspoonful of Suspension contains:

Triaminic® ..... 25 mg.
(phenylpropanolamine HCl.. 12.5 mg.;
pheniramine maleate ..... 6.25 mg.;
pyrilamine maleate ..... 6.25 mg.)
Trisulfapyrimidines U.S.P. ..... 0.5 Gm.

Dosage: Adults—2 to 4 tablets or teaspoonfuls initially, followed by 2 tablets or teaspoonfuls every 4 to 6 hours until the patient has been afebrile for 3 days. Children 8 to 12 years—2 tablets or teaspoonfuls initially, followed by 1 tablet or teaspoonful every 6 hours. Younger children—dosage in proportion.

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DIURIL® "....

CHLOROTHIAZIDE

FINNERTY, F. A., Buchholz, J. H. and Tuckman, J.: J.A.M.A. **166**:141, Jan. 11, 1958.

DIURIL (Chlorothiazide) given alone to 85 patients, ". . . caused an excellent diuresis, with reduction of edema, weight, blood pressure, and albuminuria. . . . The average effective dose was found to be 1 Gm. per day by mouth. . . . The usually excellent response coupled with the absence of significant toxicity and lack of development of drug resistance makes chlorothiazide ideal for the prevention and treatment of toxemia."

DOSAGE: one or two 500 mg. tablets of DIURIL once or twice a day.

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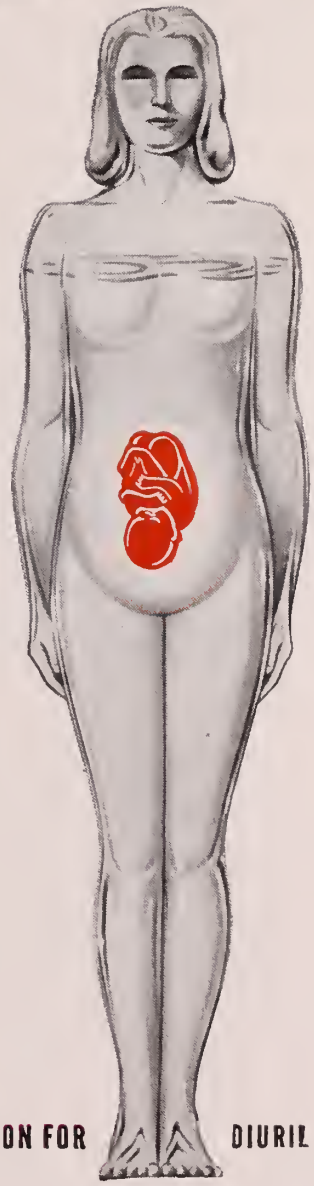

....caused an excellent diuresis, with reduction of edema, weight, blood pressure, and albuminuria...."

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provides dependable, fast, effective therapy

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because all patients show therapeutic blood concentrations of penicillin with recommended dosages.

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of the bacteria-destroying antibiotic. Within five to fifteen minutes after administration, therapeutic concentrations appear in the general circulation.

higher blood levels

than with any other penicillin given orally. Bactericidal concentrations are assured. Infections resolve rapidly.

Dosage: 125 or 250 mg. three times daily.

Supplied: Tablets, scored, of 125 and 250 mg. (200,000 and 400,000 units).

New **V-Cillin K, Pediatric:** In bottles of 40 and 80 cc. Each 5-cc. teaspoonful provides 125 mg. V-Cillin K.

V-Cillin® K (penicillin V potassium, Lilly)

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Patients receiving

NILEVAR®

Eat more...
Feel better...
Recover faster

Compared to control patients, those receiving Nilevar (brand of norethandrolone) have repeatedly demonstrated more rapid and more complete recovery from serious acute illness and increased comfort and well-being in chronic illness.

A multitude of case histories are now adding individual clinical color to the earlier controlled investigations which defined the actions of Nilevar as an effective aid in reversing negative nitrogen balance and in building protein tissue.

In typical case reports such gratifying comments as these appear:

Underweight —"Appetite considerably increased within one week. Sense of well-being and vigor increased along with increased appetite."

Prematurity (Birth weight: 2 pounds, 4 ounces) — "Gradual improvement in appetite and capacity for formula. . . . Excellent progress and weight gain for a very immature infant."

Carcinoma of the Uterus —"Within four days appetite became excellent, took full diet. . . . More ambition while on Nilevar. Enjoys life. Takes part in church and other social affairs."

Third Degree Burn —". . . soon began eating all that was offered. . . . Began to show signs of hope for recovery. . . . Perhaps one of the greatest changes was in the appearance of his wounds which were so very much improved."

The dosage for adults is 20 to 30 mg. daily in single courses no longer than three months. For children the daily dosage is 0.5 mg. per kilogram of body weight, in single courses no longer than three months.

Nilevar is supplied in tablets of 10 mg. and ampuls of 25 mg. (1 cc.).

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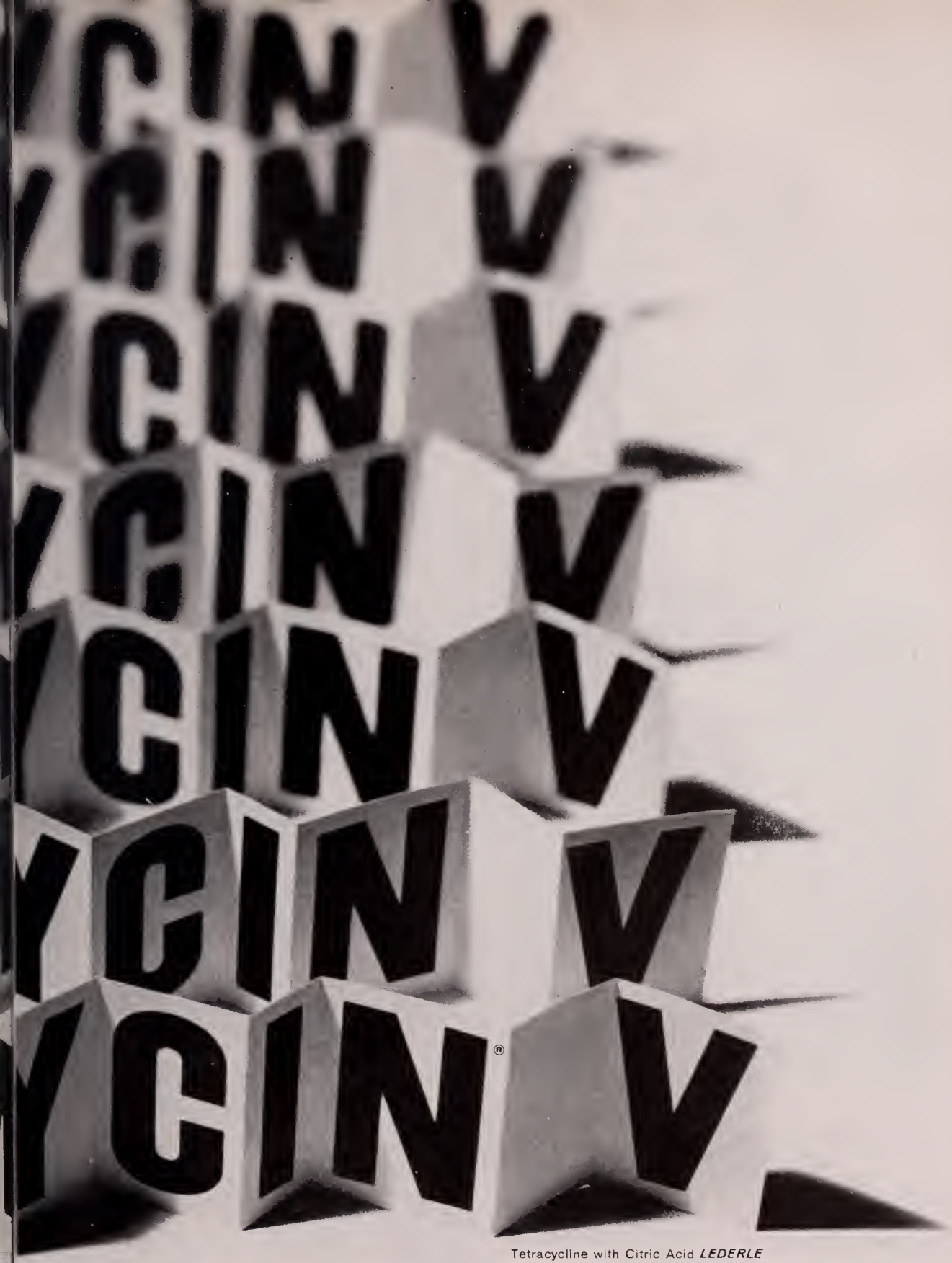

Tetracycline with Citric Acid *LEDERLE*

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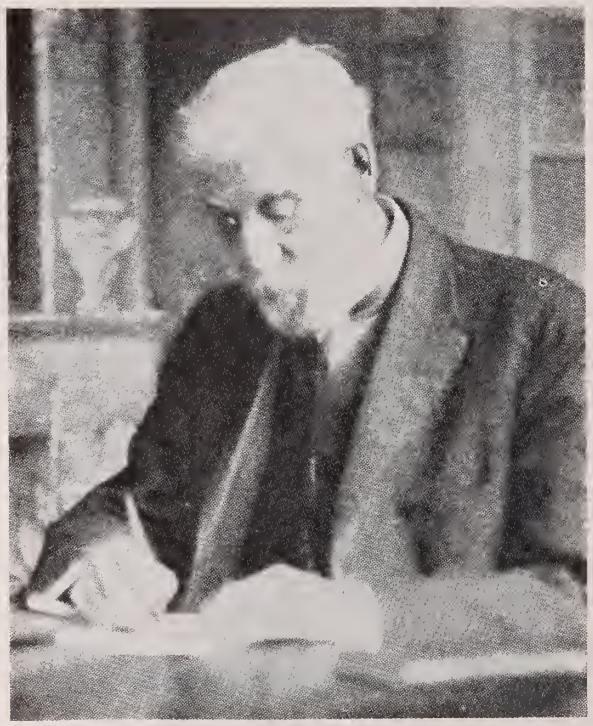
Section on Medical History

A Wisconsin doctor wrote the song, "The Little Brown Church in the Vale," seven years before the church was built several miles outside of Nashua, Iowa, in 1864.

The State Medical Society's Section on Medical History, active in research concerning early-day physicians and medicine in Wisconsin, uncovered the information that Dr. William S. Pitt wrote the song while he was practicing in Rock County (Wisconsin) 101 years ago. Much of the section's effort is directed to collecting information for the Medical Museum of Wisconsin, to be built at Prairie du Chien.



Dr. William S. Pitt

Doctor Pitt, whose spare time was spent as a voice and music teacher, came to Wisconsin in 1847 after graduation from Rush Medical School in Chicago. He was born in Orleans County, New York State.

Married in 1857, he traveled with his wife's family to northeast Iowa on a visit that year and envisioned the wooded spot near Nashua as an ideal, natural location for a country church. He told area residents that a church "just seemed to belong in this valley," and they made plans to construct one. The Civil War, however, necessitated a delay and nothing further was done until 1864.

Historians say the church was painted brown "because the parishioners were too poor to buy any other color." They knew nothing of Doctor Pitt's song at the time.

In 1864, Doctor Pitt moved with his family to Bradford, Iowa, set up an office and found time to teach singing at an academy located across the road from the new church. He taught his song to the young people, and also arranged to have it published, as a popular tune. A vaudeville team, the Weatherwax Brothers, picked it up, and sang it as a hymn. It quickly became a favorite of many Americans, and has retained its popularity for almost a century.

Doctor Pitt moved east shortly before his death in 1918, and was buried in Brooklyn, N. Y.

In the past 94 years more than 40,000 couples have been joined in marriage at the "Little Brown Church in the Vale." Last August approximately 4,000 persons from all parts of the country came to the church for a reunion and a mass repeat of their marriage vows, an annual ceremony. All of them joined in singing Doctor Pitt's famous composition, a song which gave national prominence to a little country church.

* * *

A volume, "Essays in Pastoral Medicine," has been presented to the Section on Medical History by Dr. G. J. Gumerman of Milwaukee. The book was written by two physicians, Drs. Austin O'Malley and James J. Walsh, and was published by Longmans, Green and Co., New York, in 1911.

Thirty subjects, ranging from *Hypnotism, Suggestion and Crime* to *Paranoia, A Study in Cranks*, are covered in the very readable publication.

The New President

DR. WILLIAM B. HILDEBRAND

The new president of the State Medical Society—Dr. William B. Hildebrand—assumes this high position with a background of 20 years of active participation in organized medicine.

Doctor Hildebrand was born in 1904 at Huntington, Indiana. He is a graduate of the University of Wisconsin and also Washington University, St. Louis, Missouri, where he received his medical degree in 1939. He took his internship at Northwestern Hospital and Minneapolis General Hospital, both at Minneapolis, Minnesota, from 1939–1941. He was licensed to practice in Wisconsin in 1941. A graduate of the U. S. Navy School of Aviation Medicine, Pensacola, Florida, Doctor Hildebrand served overseas in the South Pacific and China theatres with the U. S. Marine Air Corps from 1944–1946.

Following his tour of duty Doctor Hildebrand began practicing general and industrial medicine at Menasha. He is married and has three children: two daughters, one married and one a freshman at the University of Wisconsin; and a son who is a junior student at the University of Pennsylvania School of Medicine. He is a medical director of the Marathon Corporation; medical advisor for the John Strange

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EDITORIAL COMMENTS

Detection of Gastric Lesions

The paper by Lloyd K. Mark on "Roentgen Detection of Early Gastric Neoplasm" appearing in this issue of the Wisconsin Medical Journal points out the difficulty a roentgenologist has in detecting some lesions of the stomach; and this particular case report is very illustrative of this problem.

One case report is usually insignificant, but the more of these cases we have recorded in the literature, the sooner someone can gather them all together and therefore pinpoint the problem more accurately.

When all other methods of diagnosis have failed, and we still feel that there is some organic lesion present, we should probably resort to laparotomy more frequently.

We have all seen patients of this type. It is difficult not to be discouraged when reviewing their records. We can take small comfort from the knowledge that others have the same experience and can only hope for the development of a biochemical test that will reveal the presence of neoplasm while we await the discovery of its prevention or cure.

An Objective Approach

Since its inception a few years ago the Maternal Mortality Survey Committee has studied the various causes of maternal death in Wisconsin. Their findings have been made possible by the interest and cooperation of the physicians of the state. Complete anonymity has been maintained. The approach has been entirely objective. Sufficient information has been gained to highlight some of the problems. These formed the basis for a series of Maternal Mortality Institutes held in four locations in the state during the month of March 1958.

In this issue of *The Wisconsin Medical Journal* there appears an article entitled, "Obstetrical Anesthesia," which covers one of the five discussions held at the Institutes. The author is William Kreul, M.D., who is anesthesiologist at St. Mary's Hospital, Racine. Doctor Kreul is a member of the Wisconsin Maternal Mortality Survey Committee.

Socio-Economic Medicine

As you know, there is an urgency involving this matter of sound, reasonably-priced voluntary insurance for the aged. The consequences of delay and inaction will be serious, if not disastrous.

I am sure you all are aware that the forces supporting big government intervention in the health care field have plans for federal control and financing of a medical and hospital system for the aged.

Their best-known proposal, the Forand bill, would make the Social Security system responsible for providing a wide spectrum of hospital and medical benefits for OASDI beneficiaries. The measure was introduced in the last session of Congress. There is little doubt that similar legislation will be introduced in the next Congress although there may be a change in strategy. Present information indicates that the proponents may eliminate medical and surgical in-hospital benefits and may seek only hospital care for OASDI beneficiaries.

This is an obvious attempt to seek national compulsory health insurance in a bit-by-bit fashion instead of the chunk-by-chunk method or the one stroke way.

As you know, a complete national compulsory health insurance program was first sought in one all-inclusive legislative measure a decade ago. When that failed, the proponents began seeking their ends in a piecemeal manner.

Now they have publicly announced their intent to break up the pieces into bits, as in the case of the Forand bill, hoping that within a few years enough bits of legislation will be passed to make up one large piece.

Unfortunately, the tendency of some opponents of national compulsory health insurance may be to accept a bit of legislation here or there with the hope of appeasing the opposition or of satisfying a particular financial problem for themselves.

Let us not be duped into believing that one small legislative measure will quench the thirst of the proponents of a comprehensive and compulsory national health program. The enactment of a portion of a Forand-type proposal will lead quickly to passage of other portions and inevitably to full socialization of all health care.

. . . I feel that we must not only answer the pressure for the enactment of Forand-type measures

with sound arguments, but we also must bestir ourselves now and aggressively seek voluntary programs to solve the health care needs of the aged within the pocketbook capacity of the senior-citizen group.

We cannot ask ourselves: What is the other fellow doing in the field of insurance for the aged? We must ask: Where does my company stand? What are we doing to meet the challenge of this problem of the aging?

Now is the time for action, for in two years it may be too late for the private practice of medicine and the system of voluntary personal insurance.

I believe we can predict that if such Forand-type legislation is enacted the following development can be expected to occur:

1. Profound changes in the doctor-patient relationship with a certain loss of confidence and mutual respect between the two parties.
2. Expansion of medical hospital benefits to all persons under the OASDI system.
3. Higher costs than anticipated.
4. Over-utilization of hospital and medical facilities.
5. Destruction of the voluntary health insurance industry.
6. The promulgation of standards of health care and of levels of compensation to cover doctors, hospitals, nurses and ancillary professional groups.

No thoughtful, conscientious leader in this country should want any of these things to happen, but I am convinced that they will happen if the voluntary system for security is replaced with compulsory government programs.

. . . I believe that medicine, the insurance industry and patients should support wholeheartedly the struggle to uphold the fundamental principle of free choice of physician by the patient. In medical care and in the free enterprise system the freedom to choose is essential.

For medicine free choice has meant the challenge of the open market, the incentive of competitive selection, the chance to succeed or fail based on the judgments of many individual consumers, and the opportunity to develop a relationship with the patient undisturbed by outside forces of uncertain motivation.

To the patient free choice has meant the privilege of personal selection in an area affecting his life and health; it has meant the right to change physicians; it has meant control of the services by the one who receives and pays for the service.

In recent years, however, certain third parties have moved away from this fundamental principle of free choice. They arbitrarily have selected physicians for their members, and they have required members to use their physicians exclusively or pay for the services of another physician. If this idea grows in our nation, it is obvious that the profession of medicine and the patients themselves will become captives of third parties—some insurers, government, organized labor or others. And once this happens, can the domination of medicine by government be far behind? Indeed, can a totalitarian welfare state be far behind? *(Excerpts from "Socio-Economic Medicine" by Gunnar Gundersen, M.D., F.A.C.S., President, American Medical Association, Chicago, Illinois, at the 67th annual meeting of the Association of Life Insurance Medical Directors of America, October 23, 1958, at Hartford, Connecticut.)*

(continued from page 31)

Paper Company, Menasha Woodenware Corporation, and Gilbert Paper Company, all of Menasha; medical coordinator of School Health, Menasha; and a past chief of the division of medicine and a past chief of staff of Theda Clark Memorial Hospital, Neenah.

During his medical career, Doctor Hildebrand has held many positions in both state and national medical organizations and has been an outstanding spokesman for the medical profession.

Doctor Hildebrand is a past national president of the American Academy of General Practice. Other present and past positions he has held in that organization include: past chairman and member of the Commission on Membership and Credentials, past chairman and member of Board of Directors, past chairman of the Mead–Johnson Scholarship Committee, and member of the Speaker's Panel.

In the State Medical Society he is a past vice speaker and speaker of the House of Delegates, charter member of Section on Medical History, past member and chairman of Committee on Hospital Relations. He is a past secretary and charter member of the Wisconsin Academy of General Practice, past chairman of the Governor's Committee to Control the Use and Distribution of Salk Vaccine in Wisconsin, chairman of the Division of Medical Gifts of the Medical Museum of Wisconsin, member of Committee on Physician Education of Wisconsin Heart Association, and member of Board of Trustees of Interstate Postgraduate Medical Association.

Doctor Hildebrand is also a member of the Committee to Coordinate Postgraduate Medical Education of the Council on Medical Education and Hospitals, and a member of the Joint Committee on Industrial Health, all of the Americal Medical Association; past member of the Advisory Council of the National Pharmaceutical Association; member of U. S. Committee of World Medical Association; member of Editorial Board of *Modern Medicine;* and vice-president of Section on General Practice of Pan American Medical Association.

Present medical memberships held by Doctor Hildebrand are: Winnebago County Medical Society, State Medical Society of Wisconsin, American Medical Association, Aero Medical Society, Industrial Medical Association, Wisconsin and American Heart Associations, Wisconsin and American Academies of General Practice, and Pan American and World Medical Associations.

Doctor! Can You Help?

Dr. John Z. Bowers, Dean of the University of Wisconsin Medical School, has announced that the School is investigating some of the metabolic aspects of rheumatoid arthritis. He is asking for the cooperation of Wisconsin physicians. Doctor Bowers stated that "we are anxious to study patients who have active uncomplicated disease and who have not received steroid hormones for two months. About one week of hospitalization would be necessary for the studies or they could be carried out without hospitalization." Doctor Bowers would be happy to discuss the matter with any physicians who have such patients.

Missing Person!

Richard Nunley is wanted for questioning by Salt Lake County Sheriff's Office. Wisconsin physicians are asked to be on the look out for this man because it is understood that every so often, usually around the 15th of the month, he shows up to give blood (whether it is taken because of disease or whether he sells his blood, is not known). Description: height 5'10"; weight 160 pounds; blond straight hair; blue eyes; light complexion; age 26 years; last seen wearing charcoal slacks, light shirt with pink dots. If Richard Nunley's whereabouts are known please contact the Salt Lake County Sheriff, George Beckstead, Salt Lake City, Utah, or the local law enforcement office.

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THE MEDICAL FORUM

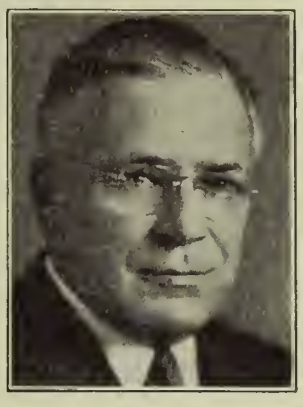
IMMUNIZATION PROGRAMS TO BE STUDIED BY SOCIETY

U. W. Med School Gets Gavel Made Of Muir Locust

MADISON—A cherished University of Wisconsin tradition was kept alive when Regents accepted, for the medical school, a gavel and sounding board presented by Dr. R. G. Arveson, Frederic.

The gavel is one turned by Prof. Walter A. Rowlands, director of U. S. Branch Experiment Stations, from the wood of the Muir Locust, the campus tree credited with inspiring John Muir to take the road that led him to world fame as a naturalist.

In the spring of 1863, when Muir, as a Wisconsin student, lived in North Hall, Milton Griswold, a fellow student, showed Muir the nearby locust tree and explained to him the relationship in form that existed between the locust flower and the flower of members of the pea family.



DR. R. G. Arveson

Muir wrote in his memoirs that "this fine lesson charmed me and set me flying to the woods and

(Continued on page 42)

MADISON—A gavel, presented by former U. W. Regent Dr. R. G. Arveson, Frederic, to the Wisconsin Medical School, receives the attention of two members of the school faculty, Dr. Frank C. Larson (left), associate professor of medicine and newly-appointed director of clinical laboratories for University Hospitals, and Dr. Robert C. Parkin, assistant to the dean of the school. The gavel was made by Prof. Walter A. Rowlands, director of U. W. Branch Experiment Stations, using wood from the John Muir (black) locust, a tree standing on Bascom Hill for many years. Dr. Arveson made the sounding board and cradle of birch.—(George Gambsky photo)

DIVISION ON SCHOOL HEALTH ASKED TO PROVIDE NEW GUIDE

MADISON—The Commission on State Department's Division on School Health has launched a survey of immunization programs in Wisconsin and elsewhere.

The purpose is to find an improved method of providing such programs through individual offices of family physicians—rather than the mass programs developed over the years.

Dr. Lloyd M. Simonson, Sheboygan, is chairman of the division. Other members are Drs. E. C. Hoyer, Beaver Dam; William A. Nielsen, West Bend; K. J. Winters, Wauwatosa; John G. Heisel, Superior; E. E. Bertolaet, West Allis and Amy Louise Hunter of Madison.

Physicians in many areas of the state have felt that the mass programs do not provide adequate supervision of the child's over-all health condition, and that individual attention through a closer doctor-patient relationship is helpful in preventing adverse reactions which occur in some immunizations.

REASONS LISTED

Typical of the problem is a recent development in Stevens Point where the Portage County Medical Society voted to end public immunization clinics in city and county schools. The county group listed these reasons for its decision:

1. The infant will be given the immunization before six months of age, which is the most susceptible age for whooping cough and diphtheria.
2. It will be an improvement over the present method in that it will help prevent adverse reactions to the immunization.
3. The child will have the judgment of the family physician who is in the best position to determine when and how his immunization should be given. Under the present method of mass immunization, this is not possible.

(Continued on page 42)

ATHLETIC INJURIES SESSION ATTRACTS HUGE AUDIENCE

Ask for Stricter Physical Testing

MILWAUKEE—More than 700 guests, including 44 physicians, attended the first Wisconsin Conference on Athletic Injuries in Milwaukee Nov. 7.

A project of the Charitable, Educational and Scientific Foundation of the State Medical Society, the conference attracted representatives of 305 schools in Wisconsin, including 480 athletic coaches, 45 physical education teachers and 21 school administrators.

The tone of the session was set by **Dr. Francis J. Millen**, Milwaukee, who said there should be less emphasis on winning and more on complete physical examinations of high school athletes.

He said that over-emphasis on victory is "unnatural" and the role of prep athletics "should be put in its proper perspective, which is contributing something to society and the school.

"The pressure of winning is not the fault of the coaches but of parents who are immature in their approach to athletics. This causes many emotional disturbances, and follows a desire for social prestige or perhaps because the parents were not able to compete when they were young.

"Athletics is not an end, but a means to an end . . . to interpersonal social relations."

Dr. Edgar S. Gordon, of the University of Wisconsin Medical School, told the large audience that there "is no evidence which proves athletics will injure the heart of a normal healthy young athlete.

"A healthy heart has a reserve capacity that is impossible to exhaust in a youngster. The youth's skeletal muscles will give out before his heart will."

Dr. Gordon said there "must be a better way of screening candidates for a sport. It has not been adequate to date. You cannot tell very much by just listening to a boy's heart with a stethoscope."

If there is any doubt about his heart, Dr. Gordon continued, there should be a decision made by a competent medical authority whether the boy should be kept from participating in sports.

"Irreparable damage has been done to a boy," he said, "and to adults, too, who have been told they are physically unfit because of a heart murmur, and were later found to have a healthy heart."

Coach Ole Jorgensen, of Neenah High School, told fellow coaches to "calm down, and leave the excitement to the crowds." He said:

"Try to calm down. The excitable coach who jumps up and down does not help his team. This not only upsets the players, but the fans and game officials as well. Maybe something should be done about the emotional problems of the coach as well as the player."

The Neenah mentor also claimed that plastic helmets are doing as much damage "physically and mentally as any piece of football equipment now in use." He suggested the helmets should be padded in some way on the outside.

Joseph P. Dolan, Ph.D., of North East Missouri State College, Kirksville, called the coach "the projection of the community, who becomes unreasonable and sometimes expects physicians to work miracles to restore an injured halfback."

Dr. Frank D. Bernard, Madison, described various kinds of head and face injuries, and outlined proper medical care, as well as coaches' recognition of these injuries. The serious nature of head injuries was stressed by the speaker, who urged the visitors to take special precautions when injuries of this kind occur.

Exercises to strengthen leg muscles, particularly those near the ankle and knee, were detailed by **Dr. Stephen E. Reid**, Evanston, Ill., physician to Northwestern University teams. He was assisted in his presentation by Ted Healion, Northwestern team trainer.

Dr. Lloyd M. Simonson, Sheboygan, chairman of the society's Division on School Health, served as moderator of the morning session, and **John E. Roberts**, Stevens Point, executive secretary of the W. I. A. A., served in a similar capacity in the afternoon.

Other physicians participating included Dr. Robert Krohn, Black River Falls; Dr. D. W. McCormick, Fond du Lac and Dr. W. D. Stovall, Madison, foundation president who welcomed the guests and told the purposes of the conference.

CONFERENCE ON ATHLETIC INJURIES—Five active participants in the conference, a project of the State Medical Society's Foundation, held in Milwaukee, Nov. 7, were (seated): Dr. Lloyd M. Simonson, Sheboygan, chairman of the society's Division on School Health, and Dr. William D. Stovall, Madison, Foundation president, who greeted the 700 guests. (Standing, also left to right) Dr. Frank D. Bernard, Madison, who presented an illustrated lecture on head and facial injuries; Dr. Stephen E. Reid, Evanston, Ill., physician and surgeon to Northwestern University athletic teams, and Ted Healion, Evanston, Northwestern team trainer, who combined to discuss knee and ankle injuries. Other subjects on the day-long program included taping and physical therapy; emotions; heart; hernia; growth, fatigue and conditioning.—(Genack Studio photo)

BREAKDOWN OF H.S. ATHLETIC INJURIES

MILWAUKEE—There were 6,222 injuries to high school athletes during the 1957–1958 school year, John E. Roberts, Stevens Point, executive secretary to the W. I. A. A., reported to the Conference on Athletic Injuries.

More than 37,100 boys were covered by the W. I. A. A. benefit insurance program, which was inaugurated in 1930, and was the first of its kind in the country. Initially it covered only athletic injuries, but in 1945 this was expanded to include all school-sponsored activities.

In 1957–1958, almost 232,000 pupils were protected by the all-school plan.

A breakdown of athletic injuries during the past year shows 809 claims because of ankle injuries, 702 knee, 692 hand and finger, 599 facial and 542 to the teeth.

Figures show that since 1930 football has accounted for slightly more than 60 per cent and basketball 22 per cent of all reported injuries in athletic competition.

Union Seeks "Full" Medical Program

NEW YORK—The United Steel Workers of America is expected to make a full medical program a major point in next year's contract negotiations, according to the *Health and Welfare Newsletter* of October, 1958.

At its annual convention, delegates unanimously adopted a resolution providing for an extensive study of their health and welfare plan and other union medical programs. The possibility in view:

"Establishing our own hospitals, clinics, diagnostic centers, rest homes, rehabilitation centers, nursing homes and the development of fully prepaid medical care plans."

The union reported some success in limiting the size of rate increases by existing health plans, but continued:

"By no means are we satisfied with the reasons given for the skyrocketing costs of our hospitalization and medical care program."

Present Mental Illness Plan

MADISON—A three-part program, designed to form a frontal attack on mental illness, was offered recently to the State Legislative Council.

State Sen. Kirby Hendee (R–Shorewood), chairman of the council's mental health committee, submitted the recommendations to the council for possible approval and presentation to the 1959 legislature. The recommendations were in the form of three bills.

To cost a million dollars, the outlined program followed a series of public hearings throughout the state and studies by committee researchers. The program calls for:

1. **Building a 30-bed residential treatment center for emotionally disturbed children in Madison, near the Wisconsin Medical School, at a cost of $500,000.**
2. Creating a mental health advisory board.

STATE AID

3. Setting up state aid for community mental health clinics and transfer child guidance clinic functions from the State Board of Health to the State Department of Public Welfare.

"These recommendations," Sen. Hendee explained, "fall together in a pattern and should be viewed in that manner.

"The adoption of one or two of the proposed bills will improve mental health services in Wisconsin, but only the adoption of all three will accomplish what we set out to do—make a frontal attack on mental illness at all levels, and thus slow the march of the mentally ill to new institutions.

NO ALTERNATIVE

"We reluctantly recommend building the treatment center because we see no alternative. Wisconsin has no such facility or even an adequate substitute. There are enough emotionally disturbed children in the state to justify the building."

The senator said the number of emotionally disturbed children resulted from the basic problem having been ignored too long. A broader based program of prevention through local guidance clinics was recommended to prevent the number of such youngsters from mounting.

The state aid program, under which the state would contribute 40 per cent of the budget of each local mental health clinic, would total $396,000 for the biennium.

Speaking of the advisory committee, Sen. Hendee said:

"Organizationally speaking, we have shut our eyes to the tremendous problem of mental health in Wisconsin too long. By this means, we hope to give it the attention it deserves."

The committee would consist of nine members, seven to be appointed by the governor. The other members would be the legislative chairmen of the public welfare committees of the senate and assembly. It would make recommendations to appropriate state agencies concerned with mental health, report to the governor and the legislature.

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MILWAUKEE WISCONSIN

Act to Create Post of Civil Air Surgeon; Follows Wisconsin Plea

MADISON—A Wisconsin's physician's program to improve airline safety through better health and medical care of the nation's pilots is gaining momentum.

Dr. L. O. Simenstad, Osceola, vice chairman of the Wisconsin Aeronautics Commission, introduced a resolution a year ago at the A. M. A. meeting in Philadelphia urging the association to seek establishment of a completely adequate and competent medical department within the Civil Aeronautics Commission. He charged that some of the commercial pilots were being given physical examinations by chiropractors and that the commission medical department was virtually non-existent.

The A. M. A. adopted the resolution and at once appealed to Congress to secure enactment of appropriate legislation. It declared that physical standards for and medical evaluation of pilots must be carried out by physicians experienced in aviation medicine.

In the past month, E. R. Quesada, administrator of the newly-created Federal Aviation Agency, asked for candidates for the position of civil air surgeon. This office will work to assure status for civil aviation medicine considerably higher than at any time under the Civil Aeronautics Commission, which will be absorbed by the F. A. A. Jan. 1.

The agency's medical head will have the task of setting fitness standards for airmen, traffic controllers and other personnel; supervise the national network of medical examinations, a function utilizing services of thousands of private practitioners; strive to improve efficiency of aviation medical examiners; encourage research in aviation medicine; develop and conduct internal health and medical programs for F. A. A. personnel, and fulfill miscellaneous duties.

Administrator Quesada has written to a number of medical organizations requesting nominations for the position. The post pays $19,500 annually to start. There is no stated age ceiling.

The Washington Report on the Medical Sciences, in a recent issue, commented:

"Under the F. A. A., medicine will have far greater recognition. Administratively, it will no longer be buried under layers of bureaucracy, a situation to which we have called attention at various times over the past 10 years. The doctor selected as civil air surgeon will report directly to Administrator Quesada."

Dr. L. O. Simenstad

ASSISTANTS NAME NATIONAL OFFICERS

CHICAGO—Two Wisconsin medical assistants were elected to officer posts at the second annual meeting of the American Association of Medical Assistants last fall.

Lois Pluckhan, Madison, was named recording secretary, and Alice Budny, Milwaukee, to the board of directors.

The new president-elect is Marian Little of Cedar Rapids, Ia.

Dr. Robert J. Samp, of University Hospitals, Madison, delivered the banquet address, urging the assistants to be on constant guard against the inroads of quacks, and to initiate educational campaigns to fight quackery.

Harold E. Scherer, manager of the Monroe Clinic, speaking at the general session, asked for more attention to dress, personal betterment, friendliness and continued education.

"Be qualified for your position, or the one you want to advance to, and stay qualified," Scherer said. "A medical assistant with skills and the right attitude has nothing to worry about."

More than 475 assistants from 30 states attended the meeting.

Pitt Creates Health Law Center

PITTSBURGH, PA. — Long known as a leading medical research center, the University of Pittsburgh has moved a step further by establishing a health law center.

The health law center was created to extend the school's activities well beyond the scope of laboratory research into the comparatively unexplored field of health and hospital jurisprudence.

The new center functions within the graduate school of public health, and was made possible by a $234,528 grant from the National Institutes of Health. Its first director is John F. Horty jr., an attorney and associate research professor of health law.

The initial project is to publish the results of a two-year, 48-state study of hospital law. Findings will be presented next spring in two volumes, one for hospital administrators and the other for hospital attorneys.

Then will follow extension of operations into other fields of health law, nursing, public health, dentistry and pharmacy, as well as medicine.

Ask Insurance Plan Stressing Preventive Medicine

NEW YORK—Blue Cross and Blue Shield have been challenged by the president of the International Association of Machinists to emphasize health insurance that provides preventive medicine and early treatment of disease, according to the *Health and Welfare Newsletter* of October, 1958.

Al Hayes, IAM president, recently told Blue Cross and Blue Shield executives that **"it is high time that we stop emphasizing insurance against the high costs of neglected health and devote more of our efforts to developing a system of insurance or prepayment which will give the American people greater access to the kind of health care which prevents or nips it in the bud."**

Hayes criticized health insurance that is tied to hospitalization, driving people to hospitals so they can get insurance coverage for care which could be provided in the home or doctor's office.

Code Bans TV "Men in White"

DENVER—Those men in white who look like physicians or dentists on TV commercials may be on their way out of your living room, according to Safeguard, official publication of the Better Business Bureau.

This refers to the tonic and toothpaste ads that try to lend credulity to messages delivered by dressing up actors as doctors or dentists and putting them in mock offices.

The Television Code Review Board of the National Association of Broadcasters has issued a ban on these ads. Previously, the board permitted such promotion as long as the words *"A Dramatization,"* appeared for at least 10 seconds on the screen.

The new ban precludes:

Appearances in ads of physicians, dentists or nurses, even though such portrayals are visual only.

Use of props or settings which might give viewers the impression the individual speaking is a member of the medical, dental or nursing profession when, in fact, he is not.

References by announcers and TV pitchmen to scientific research, studies or surveys may be used only if there is actual evidence such took place, and is on record.

The board said filmed commercials, produced before June 18, 1958, may be used until Jan. 1, 1959. No films newer than that can be used.

LET EDITORS KNOW!

PHOENIX, ARIZ.—If you are not happy about the kind of newspaper publicity your society gets, take a tip from the Maricopa County (Phoenix) Medical Society, and tell your editors about the good things doctors do.

The society supplied an idea and source material to the *Arizona Republic* and a reporter took it from there. The result was a series of articles on why good medical care costs money, under the headline "Your Doctor Has Earned His Fee!"

TO USE REAL DOCTORS IN TV COMMERCIALS?

NEW YORK—The possibility that certified doctors of medicine may be used in TV commercials after the National Association of Broadcasters' ban against "actor doctors" goes into effect Jan. 1 is worrying the medical profession, according to a recent article in *Advertising Age.*

The publication stated that the New York County Medical Society has suggested that physicians not endorse medicines on TV. The suggestion was made after three young doctors reported they had been offered jobs on TV commercials.

The society apparently fears, *Advertising Age* said, that advertisers and agencies will decide the best way to circumvent the intent of the ban on "white coat" commercials will be to hire real men of medicine.

The society raised these questions:

Should any M. D. choose to be a pitchman and a replacement for a professional actor?

Shouldn't a physician devote his efforts to medicine and not to advertising?

After he finishes with TV advertising, will the TV physician be able to return to the practice of medicine with his stature undiminished?

NEKOOSA—Functional design and shiny new equipment made a hit with visitors to Nekoosa's new medical offices this past summer. The building is owned by Drs. John E. Thompson and Louis R. Pfeiffer.

The center also houses a dentist, x-ray technician and two nurses.

Five examining rooms, an x-ray room, a general business office and reception area, orthopedic room and private offices are features of the medical section. Additional facilities include a fully-equipped laboratory and an emergency operating room.

The building, which covers 4,000 square feet, has a brick exterior. Inside fluorescent lighting, forced air heating and air conditioning are other features.

The physicians, both newcomers to Nekoosa, were classmates at the University of Wisconsin Medical School.

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Brown County Aged, Chronically Ill Pilot Program Underway

GREEN BAY—A new pilot program in care of the aged and chronically ill, financed by a $62,000 federal grant, began in Brown County last fall.

Purpose of the study was defined "to develop and conduct a special project aimed at demonstrating the value of a rehabilitation program for the aged which would alleviate the disabling effects of chronic disease and return many bedridden patients to self-care and useful living."

The project was approved earlier by the Brown County Medical Society and ancillary groups. Initially, it will be limited to aged persons now living in nursing homes under jurisdiction of the State Board of Health.

Dr. G. M. Shinners, district health officer in Green Bay, will head up the program, and be assisted by Mr. George K. Shaber, formerly of the New Mexico Department of Health.

Dr. Milton Feig, Madison, of the State Board of Health's Section on Preventable Diseases, said additional personnel would consist of two physical therapists and a consultant chronic disease nurse on a part-time basis. As additional funds become available, it is expected that one or more medical social workers, one or more occupational therapists and a full-time consultant nurse would be employed to assist in the effort.

"Simultaneous with the development of the program in the nursing homes around Green Bay," Dr. Feig explained, "we now plan to conduct in-service training institutes for public health nurses and other interested groups in eight counties surrounding Green Bay.

"The purpose for this is to expand restoration services to include the partially disabled, elderly persons living at home. It is my belief that this will ultimately constitute the major aspect of the restoration program."

Similar programs in other parts of the country have shown that large numbers of the aged can be taught to care for themselves, and to return to private living upon discharge from nursing homes.

Dr. Feig said Brown County was selected for the study because of the presence of adequate medical services and facilities, and large number of aged persons living in convalescent homes. The latter figure is close to 500, and all are being contacted to participate.

The evaluation of the entire project shall be the responsibility of Dr. Shinners, aided by family physicians and other staff members. This will include evaluation of the feasibility of a patient for rehabilitation and the progress of the patient during rehabilitation; progress reports on patients discharged to the care of their families or other home care, and evaluation of nursing home cooperation.

Fees for the initial general physical examination and evaluation are to be established by the county medical society. It is understood that such fees will be in accord with those regularly established by the society. When consultation by a specialist is recommended by the family physician following a physical examination, the fees for such service shall be those established by the society and shall be in accord with the usual fees for such services.

All recommended laboratory work shall require the special approval of the district health officer and fees for such service shall be those standard in the area.

When surgery is required prior to the establishment of rehabilitation services, the costs for such surgery shall be borne by the patient if possible, and otherwise by some other agency. This will not be borne by the State Board of Health, Dr. Feig said.

In brief, this is how the program operates:

In each nursing home participating in the demonstration, a complete evaluation and classification is made of all patients. This consists of a complete and comprehensive medical history taken by the public health nurse; a complete physical examination by the patient's physician, reimbursable by the board on a fee basis; special medical consultation where required by local internists, orthopedists, psychiatrists, etc., also reimbursable by the board; and a social study of the patient and his family by a full-time social worker. Prescription for physical therapy is made by a physician for the therapist assigned to the project.

Following evaluation, classification and prescription for therapy, the therapists will provide daily to weekly visits to the patients in the nursing homes, at which time they carry on a training project for the home operators and personnel in order that the therapy prescribed is continued during the absence of the therapists.

When medical care is prescribed by the physician for such patients or restorative surgery required, the social worker attempts to make arrangements through local welfare and other resources to obtain necessary care. Arrangements for vocational rehabilitation, if prescribed by the physician, also are made at this time.

When the patient has progressed to the point where he could be returned to his home, the social worker makes arrangements for his homecoming and for continued therapy, vocational training and medical care. Public health nurses follow up such cases and evaluate from time to time the success of the project.

The program deadline was set at 1961, although this is flexible and may be extended upon recommendation of Dr. Shinners.

Russian Children Healthier, MD Says

PHILADELPHIA, PA.—Russian children appear healthier than those in America, the president of the American Pediatric Society believes.

Dr. Joseph Stokes, chief physician at Children's Hospital here, recently returned from a one-month visit to the Soviet Union. He took part in an exchange program sponsored by the American Friends Service Committee.

"The Russians are doing a better job of preventive care than we are," he said. "Their doctors see every child periodically from birth through school. Here not every child is seen.

"Roughly, two out of three doctors there are women. They give their patients, particularly children, good, warm-hearted medical care."

Dr. Stokes also said the Russian youngsters behave better than U.S. children "probably because they are given more affection and fewer war toys or playthings suggestive of violence."

HEALTH PROJECTS KEEP 4-H CLUBBERS BUSY

Keeping Well Regarded as Prime Interest

MADISON—Scrapbooks, posters, talks, committee meetings, films, pamphlets, window displays, pictures, demonstrations, exhibits, cartoons, newspaper and magazine clippings. . .

By these means, and others, the 50,000 members of 4–H clubs in Wisconsin show their interest and zest for health programs, regarded as one of their prime projects.

Since 1953, the State Medical Society of Wisconsin has rewarded leadership in 4–H health activity with yearly subscriptions to Today's Health. Right now 27 club leaders are receiving the publication every month, and pass it on to their members. The society also provides a $100 scholarship every year.

Other awards for outstanding effort in this category of 4–H Club activity include medals of honor, certificates of achievement, trips to the National 4–H Congress and college scholarships.

Every club program, leaders tell you, should include health activities. The goal, as expressed in the club pledge, is **Health for Better Living.** Members are urged to arrange programs and activities which reflect the needs and interests of the members, and bring out such things as safety, personal health habits, physical and dental examinations, immunizations and knowledge of diseases.

Family and personal health record books and cards were distributed to members, with the material supplied by the State Medical Society. These have proven very popular, and checks show that the information has been kept up to date quite well by almost all of the membership.

With the theme "Health for Happiness," a statewide program was set up in 1956. The first year was dedicated to promoting dental health, 1957–1958 to understanding oneself and others, with stress on getting along with others and improved mental health; 1958–1959 to home safety; 1959–1960 to individual health problems, such as posture, grooming, nutrition, and 1960–1961 to sanitation.

ONE OF THE HEALTH PROJECT activities for the Barron County 4-H Bears Club was making first aid kits at one meeting in 1958. Under the leadership of Mrs. Bertina Degerman, of Barron, the clubbers followed instructions about packing gauze, tape, band-aids and disinfectants into a handy packet. The plan was outlined by their family physicians. Some of the boys planned to strap the newly-arranged kits on their bicycles or tractors, while a number of the girls planned to keep them handy at home and in school. Others said they intended to put the kit in the glove compartments of the family automobiles.

Suggestions for activities were sent to county leaders, and in turn forwarded to club officers. First there is a period of planning, and the remainder of the year devoted to active participation. To give you an idea, here is how one group, Washington County, reacted to these outlines:

With 752 members, 439 reported having dental examinations during the past year; 225 helped give talks, set up booths on various health subjects related to mental health; 107 meetings were held; 140 talks on health were presented; 32 health demonstrations prepared and shown; 76 general discussions went on the record; 500 members maintained the Family Health Records: eight scrapbooks were prepared; 86 posters drawn and displayed, and three health skits presented to large groups.

That is quite typical of the activity, according to Agnes M. Hansen, assistant state 4–H club leader, associated with the Agricultural Extension Service in Madison.

"We had the cooperation of grownup leaders and helpers, but the youngsters entered into the health project with great enthusiasm, and did just about everything possible to put the ideas across," she said. "These boys and girls have became health conscious, certainly, and will be healthier now and in the years to come as a result."

Miss Hansen said the State Medical Society has contributed greatly to incentive, and to encouraging the young people to be active in health projects, and that the cooperation of local physicians has always been exemplary.

Food Quackery Pin-Pointed in New Film

CHICAGO — A new 27-minute film, "The Medicine Man," dramatically pinpoints the battle against quackery in the food and nutrition field.

Produced by the A.M.A., the film, prepared especially for airing over local TV stations under the auspices of county medical societies, shows how the quacks dupe the public into spending millions of dollars on unnecessary or overpriced food supplements.

Copies of the film may be obtained without cost from the A.M.A. or from the State Medical Society, Box 1109, Madison 1, Wis.

GAVEL . . .

(Continued from page 35)

meadows in wild enthusiasm." This enthusiasm he carried with him into his work in forest conservation, work which earned for him the title of **"father of our national park system."**

With constant care, the university managed to keep the tree alive until 1953, and when it died, saved the wood. From some of it, Prof. Rowlands turned a set of gavels which were presented to conservation and state leaders.

Dr. Arveson, a past president of the State Medical Society and chairman of its council, and a member for eight years of the university regents, received one of the gavels.

EDITOR'S NOTE

This news story appeared in the Nov. 8 issue of The Capital Times, Madison.

The presentation to the medical school was a return of the gavel to the university. As a regent, **Dr. Arveson** took great interest in the medical school. He accompanied the gavel with a special cradle and sounding board, which he made of birch.

The gavel and sounding board will be used, in the future, to call meetings of the university medical school faculty into session. A similar cradle and sounding board, made by **Dr. Arveson,** from wood from a bannister in old Music Hall, is used each month in Board of Regents' meetings.

The design for the cradle came from *The Journal of Surgery and Obstetrics,* an issue of a few years back. It was made and presented by the Australian Navy to the British Navy in memory of valiant service rendered.

Federal Health Costs Soar

WASHINGTON, D. C.—Uncle Sam is spending 62.6 per cent more for federal health programs than he did five years ago, and 13.5 per cent more than last year.

Programs in 22 separate agencies and departments of government range from cancer research to federal employee clinics and total $2,886,260,831, or $344,700,000 more than a year ago.

IMMUNIZATIONS . . .

(Continued from page 35)

4. The family doctor will also have at his immediate disposal a complete record of his patient and more intelligently may advise and advocate to the parents what the patient is in need of.

Commenting editorially on this decision, the *Stevens Point Daily Journal* stated:

". . . Without the convenience of public meeting places, such as the schools, and the educational aspects that have accompanied the program, the individual response for immunization is unlikely to reach the proportions of the past. An avenue through which teachers, nurses and parents have worked cooperatively and publicly with the doctors, has been closed.

"The community clinic program has met the test of time over several decades and has demonstrated its value in safeguarding the health of hundreds of thousands of youngsters in Wisconsin. It could not be conducted without the backing, the encouragement and blessing of the medical profession. Even as it is being dropped here now, it is continuing elsewhere. Immunization clinics on a countywide basis are going forward in the three neighboring counties of Wood, Waushara and Marathon.

"The Stevens Point Board of Education has asked the medical society to reconsider its action. We think it should do so."

Dr. F. W. Reichardt, a member of the county society and the board, expressed the view that the society's action should have included an alternative plan.

However, he said, there were justifiable criticisms of the mass clinics. Allergic reactions to shots and lack of records were two points mentioned by the physician.

"We do not have good records of who was inoculated in the past," Dr. Reichardt said. "There was a tendency for people to come just because it was offered. There was lot of room for improvement in the mass program."

Referring to the board's request for the society to reconsider its decision, he said:

"It looks to me as though this is wide open at this time. I think the society is willing to listen and at least explain its position further. The important thing is that we inoculate as many people as possible."

In a correlating action, the Dane County Medical Society voted last January against giving mass physical examinations to pupils planning to participate in athletics. This change, made to allow family physicians to give pupils more thorough checkups before taking part in competitive sports, is in accord with policies of the Wisconsin Interscholastic Athletic Association which has never advocated the practice of group examinations.

The division hopes to provide a guide for county medical societies and local boards of health to follow in making a gradual transition from mass immunization programs to more individual attention, if such is found feasible.

SEVEN WISCONSIN PERSONS SERVE ON A.H.A. COMMITTEES

CHICAGO—Seven Wisconsin persons are represented on 10 committees of the American Hospital Association, appointed to serve until the organization's annual meeting in 1959.

Stuart K. Hummel, of Columbia Hospital, Milwaukee, was named to three committees, on Listings, International Relations and on Paramedical Groups.

Joseph G. Norby, hospital consultant, Milwaukee, is a member of the Joint Committee with the American College of Hospital Administrators and the Committee on Headquarters Building.

Other Wisconsin persons on A. H. A. committees:

The Rt. Rev. Msgr. Edmund J. Goebel, archdiocesan director of hospitals, Milwaukee, Board of Trustees; Mrs. Cecil D. Snyder, of Kenosha Hospital, on Financing Hospital Capital Requirements; Robert M. Jones, Waukesha Memorial Hospital, on Housekeeping in Hospitals; Robert E. Griffith, Appleton Memorial Hospital, on Purchasing, and Riley McDavid, Kenosha Hospital, on the Council on Administrative Practice.

DOCTOR!

Have you sent in your entry for the Wisconsin Physicians' Photography Exhibit? Do so today!! Write to Box 1109, Madison 1, Wis.

NOW IS THE TIME....

To Prepare Your Entries for the

Wisconsin Physicians Photography Exhibit *

ENTRY CLASSES:

CLASS A • "PHYSICIANS AT WORK"
Pictures must show practicing doctors in their offices, hospitals, homes of patients or laboratories, illustrating some phase of their professional activities.

CLASS B • "PHYSICIANS IN RESEARCH AND TEACHING"
Pictures must show doctors engaged in some phase of research effort, in some form of teaching, at a hospital, postgraduate circuit program, school or allied location.

CLASS C • "PHYSICIANS AND HISTORY"
Pictures may not be current. They must show some phase of medical practice, teaching, research or allied activity; or some building, location, article, instrument, place or thing closely related to medicine in years past.

CLASS D • "PHYSICIANS IN PUBLIC SERVICE"
Pictures must show doctors performing some public service activity, such as blood bank, immunization clinic, civil defense, or participating in an activity involving lay groups or individuals.

CLASS E • "PHYSICIANS AT PLAY"
Pictures must show doctors engaged in some sport, hobby or other form of relaxation.

★ A project of the State Medical Society's Charitable, Educational and Scientific Foundation, Inc., in cooperation with the Section on Medical History.

For information about the exhibit, and a set of rules, write:
State Medical Society,
Box 1109, Madison 1, Wis.

Council on Scientific

Dates: May 5-6-7, 1959

MELVIN F. HUTH, M.D.
General Program Chairman

1959 Annual Meeting Plans Are "Cooking"

1959 Annual Meeting Plans Announced

LECTURES • EXHIBITS • DEMONSTRATIONS

TUESDAY, MAY 5

GENERAL PRACTICE DAY

(Six Hours of Category I)

Panel on "Duodenal Ulcer" and Lectures on Vascular Surgery, Radiation, Congenital Heart Disease, etc.
E. H. ELLISON, M.D.: Milwaukee
C. J. DE LOR, M.D.: Columbus, Ohio
J. T. PHELAN, M.D.: Madison
R. K. LOEFFLER, M.D.: Madison
J. W. DU SHANE, M.D.: Rochester, Minn.
MARC HOLLENDER, M.D.: Syracuse, N.Y.

THURSDAY, MAY 7

ANESTHESIA: V. K. Stoelting, M.D., Indianapolis; Solomon G. Hershey, M.D., New York City

DERMATOLOGY: Earl Osborne, M.D., Buffalo, N.Y.; Sture A. M. Johnson, M.D., Madison; Anthony C. Cipollaro, M.D., New York City; Stephen Epstein, M.D., Marshfield

OPHTHALMOLOGY & OTOLARYNGOLOGY: John M. McLean, M.D., New York City; John K. Scott, M.D., Madison; Herbert Gillet, M.D., Milwaukee. Kenneth Devine, M.D., Rochester, Minn.

RADIOLOGY: Fred J. Hodges, M.D., Ann Arbor, Michigan; John A. Campbell, M.D., Indianapolis

SURGERY: Program being developed by Wis. Surgical Society: E. A. Bachhuber, M.D., Program Chairman

WEDNESDAY, MAY 6

INTERNAL MEDICINE: Program being developed by Wis. Soc. of Int. Medicine: Robt. Baldwin, M.D., Program Chairman.

OB & GYN: Program being developed by Wis. Soc. of Ob & Gyn: James McGill, M.D., Program Chairman.

PSYCHIATRY: Marc Hollender, M.D., Syracuse, N.Y.; Special panel on "Schizophrenia" with Edward Burns, M.D., Madison; Wm. Studley, M.D., Milwaukee; and Samuel Black, M.D., Milwaukee, as participants.

PEDIATRICS: Sherman Little, M.D., Los Angeles; J. W. Du Shane, M.D., Rochester, Minn.; Gerald Kerrigan, M.D., Milwaukee; Heyworth N. Sanford, M.D., Chicago

SPECIAL PROGRAM ON SURGERY: Being developed with Wis. Society of Orthopedic Surgery: James Nellen, M.D., program chairman. Will cover orthopedic and plastic surgery

ALUMNI LUNCHEONS

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Tuesday, May 5

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SCIENTIFIC EXHIBITS AND TEACHING DEMONSTRATIONS

OFFICIAL CALL FOR

Scientific Exhibits

★

1959 ANNUAL MEETING MILWAUKEE MAY 5–6–7

★

THE Council on Scientific Work is desirous of knowing which members of the State Medical Society are interested in presenting scientific exhibits in connection with the 1959 Annual Meeting. The exhibits will be located in Bruce Hall of the Milwaukee Auditorium.

To facilitate arrangements for the proper location of the scientific exhibits, individuals and organizations desiring space at the 1959 meeting are requested to file an application BEFORE JANUARY 1, giving a full description of the exhibit, the amount of space required, and the basic equipment which will be needed.

In-state exhibitors will have the following facilities provided by the State Medical Society: Velour booth, electrical connection, shelving or tables, and identifying sign.

The exhibitor must furnish: Transportation costs of exhibit, special radiologic viewing boxes, special chrome furniture or rugs, special lighting equipment, and half the cost of any drapes rented (rented through Badger Flag and Decorating Company at time exhibit is installed).

Booths for scientific exhibits will have dark maroon velour background, 8′ in height, and ***8′ velour side dividers (not the 3′ dividers shown on the illustration).***

No exhibit may exceed a height of 7′ from the floor.

Counters (3′ high and 20″ wide) or tables (30″ high and 3′ wide) are available for viewboxes or displays to be raised above floor level.

Spaces can be allocated in 10′ units.

Those interested in providing an exhibit are required to file an application and a full description of the exhibit by January 1. *No applications can be accepted after that date.* Address your communications to Roy B. Larsen, M. D., director of scientific exhibits, % The State Medical Society of Wisconsin, Box 1109, Madison 1, Wis.

APPLICATION

For Participation in the Scientific Exhibit

1959 ANNUAL MEETING **MILWAUKEE** **MAY 5-6-7**

Fill Out and Mail to:

ROY B. LARSEN, M. D., *Director of Scientific Exhibits*
c/o State Medical Society of Wisconsin
Box 1109
Madison 1, Wisconsin

---

1. Title of exhibit: _____

2. Description of exhibit (attach 200-word description to this blank): _____

3. The standard booth is 10′ wide and 9′ deep. What is the *minimum* space your display will require? 10′ 20′ 30′ (Circle One)
(Space is scarce so do not request more than is necessary).

> In figuring space, bear in mind you can use up to 8′ on each side in addition to back wall space of 10′ (less than 8′ if your display fills the entire back wall width).

4. Will radiologic viewing boxes be used? If so, will you furnish them? _____
(The State Medical Society does not have equipment of this character available).

5. Name of exhibitor: _____

6. Name of institution cooperating in exhibit: _____

ANNUAL MEETING FEATURES: MAY 5–6–7, 1959

TUESDAY: General Practice Day *(Category 1 credit for Academy members!)*

WEDNESDAY: Special Programs on Internal Medicine, Obstetrics and Gynecology, Psychiatry, Radiology, and Special Surgical Problems.

THURSDAY: Special Programs on Anesthesia, Dermatology, Ophthalmology and Otolaryngology, Pediatrics, and Surgery.

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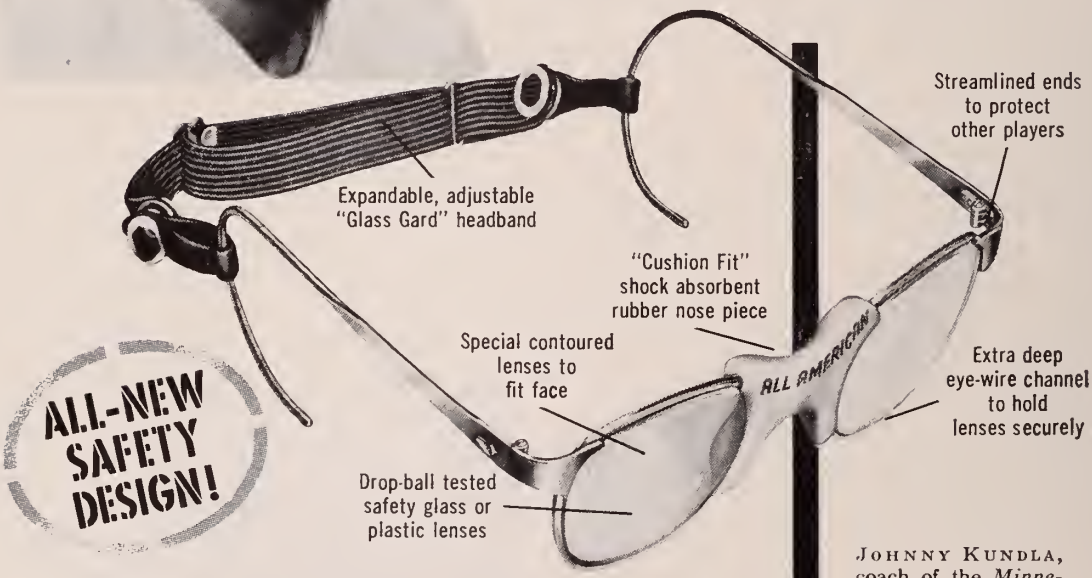

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Society Proceedings*

Dane

At the October 14 meeting of the Dane County Medical Society the following officers were elected to office for the coming year—1958–1959—for those terms which expired:

Dr. F. E. Mohs, President-elect
Dr. P. B. Golden, Vice-president
Dr. A. P. Schoenenberger, Secretary-Treasurer
Dr. C. K. Kincaid, Board of Trustees
Dr. R. S. Gearhart,
Dr. T. J. Nereim, and
Dr. C. W. Stoops, Delegates
Dr. C. A. Doehlert,
Dr. N. M. Clausen, and
Dr. R. P. Sinaiko, Alternates

On November 5 and 6, Dane county physicians attended an orientation program concerning the utilization of a 200-bed emergency hospital. The program was held at the new Wisconsin Center building in Madison. *Dr. Marvin E. Sattler*, Milwaukee, who recently attended a course in "The Management of Mass Casualties" at Walter Reed Medical Center in Washington, D. C., discussed the care of casualties at both days' sessions; and Mr. Louis Remily, assistant co-director of health services in civil defense of the State Board of Health in Madison, spoke on the purpose of the emergency hospital and the supplies and equipment used in the hospital unit set up for demonstration.

A number of these 200-bed emergency hospitals have been stored throughout the state. Medical and hospital personnel are being familiarized with the equipment and supplies in each of these hospitals.

Fond du Lac

Twenty-three members of the Fond du Lac County Medical Society were present at the Elks Club in Fond du Lac on October 23 to hear a lecture by Dr. A. Yale Gerol. The Monroe Clinic physician chose "Headaches" as the subject of his talk.

During the business session the members discussed the controversy between Wisconsin Physicians Service and Surgical Care and instructed the secretary to write Surgical Care for a list of the physicians in Fond du Lac county currently participating in their program and the date when they began. The Welfare Committee reported that the proposed fee schedule presented by the medical society had been rejected by the County Welfare Board.

Jefferson

Assemblyman Byron F. Wackett addressed the Jefferson County Medical Society on October 18. The meeting was held in Fort Atkinson.

Polk

On October 16 the Polk County Medical Society met at the Lagoon in Balsam Lake as guests of *Dr. Fred Riegel* of St. Croix Falls. Following a dinner, Dr. Milton Reiser of the Department of Urology at the University of Minnesota spoke on "General Urologic Problems for the General Practitioner."

In the business session the group approved the x-ray survey accompanied by a blood pressure checking. They also elected officers and chose *Drs. Marwood Wegner*, St. Croix Falls, as President, *Dean Ericksen*, St. Croix Falls, as President-elect, *Lewis Weller*, Osceola, as Secretary-treasurer, *L. O. Simenstad*, Osceola, as Delegate, *Robert Moore*, Frederic, as Alternate delegate, and *William Fischer*, Frederic, as Censor.

Sauk

The Sauk County Medical Society met at Herman's Restaurant in Baraboo on October 14. Guest speaker for the occasion was *Dr. Robert F. Schilling*, Madison, who talked on "The Practical Diagnosis and Treatment of Anemias." Seventeen members were present.

Washington—Ozaukee

The Grafton Hotel at Grafton was the site of the October 23 meeting of the Washington-Ozaukee County Medical Society which forty-five physicians and their wives attended. Mr. Donald Niebuhr of the State Pharmaceutical Society spoke before the Woman's Auxiliary on "Sale of Indecent Literature". The main topic of business for the evening was medical insurance and the physicians' relationship to it.

Dr. James Schultz of Jackson was admitted into membership of the county society. He is associated in practice with *Dr. James Albrecht*.

Waukesha

An interprofessional meeting with the Waukesha County Medical Society and the Waukesha County Dental Society was held at Merrill Hills in Waukesha on October 15. The members were addressed by State Senator Kirby Hendee of Milwaukee. The fol-

* Physicians whose names are printed in italics are members of the Society.

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lowing elected legislative representatives from the area also attended and spoke to the group on problems of mutual interest: U. S. Representative Donald Tewes, Waukesha; Assemblyman Harold Clemens, Oconomowoc; and Assemblyman Alvin Redford, Waukesha.

Later in the program a report was presented on the House of Delegates special session held in September at Stevens Point.

Winnebago

The regular monthly meeting of the Winnebago County Medical Society was held October 30 at the American Legion Clubhouse in Oshkosh. The buffet dinner meeting was presided over by Dr. William McConahay, a male internist from Rochester, Minnesota.

Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology

Members of the Wisconsin-Upper Michigan Society of Ophthalmology and Otolaryngology met Saturday and Sunday, September 16 and 17, at the Eagle Waters Resort at Eagle Waters.

During the Saturday afternoon session, *Dr. O. M. Hitch*, Green Bay, acted as moderator. The following papers were presented: "Congenital Cataract" by *Dr. E. G. Nadeau*, Green Bay; "Monocular Cataract" by *Dr. W. W. Ford*, Green Bay; "Complicated Cataract" by *Dr. W. J. Troup*, Green Bay. General discussion from the floor followed the presentation of these papers.

A social hour and dinner followed this session on Saturday evening.

Sunday morning *Dr. J. H. Russell*, Appleton, acted as moderator with the following papers being presented: "Tracheal Stenosis" by Drs. J. H. Russell, W. S. Jones, Jr., Menominee, Michigan, and W. J. Troup, Green Bay; "Cavernous Sinus Thrombosis" by Drs. W. S. Jones, Jr., and J. H. Russell. There was general discussion from the floor. A business meeting followed the morning session.

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D 27

News Items and Personals*

Doctor Opens Abbotsford Practice

In the fall, Dr. Gustav Schupmann, a graduate of the Loyola University School of Medicine, moved to Abbotsford to open offices for the practice of general medicine, obstetrics and surgery. Until recently he had practiced in Chicago.

Doctor Schupmann's varied background consists of an internship at St. Joseph's Hospital and postgraduate studies in obstetrics and gynecology at Little Company of Mary Hospital, both in Chicago; attending physician for several athletic teams; industrial surgery; physician of the National Guard for five years; member of the Chicago City Health Department and State Medical and Relief Department; memberships on the staffs of the Chicago city prison, Alexian Brothers, St. Joseph's, Kenner, and Roosevelt Memorial Hospitals; and services for the Chicago Venereal Disease Clinic and the Chicago Maternity Center. During World War II he served as a major in the infantry and taught at the University of Heidelberg, Germany, for the government intelligence and education program.

Pediatrician Affiliates with Gundersen Clinic

The Gundersen Clinic, La Crosse, has announced that Dr. Per J. Helliesen has been added to its pediatrics staff. Doctor Helliesen was born and raised in Oslo, Norway. During World War II he spent three years in a German concentration camp and upon release entered the University of Zurich Medical School, graduating in 1951. In 1952 he served in the Norwegian Army as a medical officer. The next year Doctor Helliesen interned in the pediatric service of Boston City Hospital, and in 1954 he served as assistant to the county physician in Tjome, Norway, and was also attached to a home for maladjusted children. He returned to the states in 1955 and spent two years as assistant senior resident in pediatrics of the Boston City Hospital. He also studied pulmonary physiology at the Children's Medical Center and Harvard Medical School in Boston.

New London Doctor Moves Office

Dr. P. F. Pfeifer announced that he has purchased the Frank Zaug building in New London and will move his office there. He had been located in the same office in that city for the past 35 years.

* Physicians whose names are printed in italics are members of the Society.

Dr. R. G. Arveson Honored

On the occasion of his seventy-fifth birthday and fiftieth year of practice in Frederic, a party was held on October 13 in honor of *Dr. R. G. Arveson.* The physician's friends gave a banquet followed by a program and open house to which the entire community was invited.

Doctor Arveson graduated from the Wisconsin College of Physicians and Surgeons in 1906. Upon completion of an internship at St. Joseph's Hospital, Milwaukee, he was physician and surgeon for a lumbering company in Hiles until 1909. Since that time he has been a continuous resident in Frederic with the exception of a year in the U. S. Navy during World War I.

Dr. R. G. Arveson

Having always taken an active part in community affairs, Doctor Arveson formed Frederic's first hospital in 1916 which he later turned over to the village, served as village president for a number of years, held a position on the county board, and headed many committees designed to improve living conditions. For several years he served on the University of Wisconsin Board of Regents. Active also in medical activities Doctor Arveson held the post as president of the State Medical Society in 1939; and is currently chairman of the Council.

Wonewoc Doctor Joins Hillsboro Hospital Staff

Dr. Homer P. Baker, Wonewoc, is now a member of the medical staff of St. Joseph's Memorial Hospital at Hillsboro. Doctor Baker established a practice in Wonewoc in 1950 and is a member of the executive committee of the staff and chairman of the tissue committee at the local hospital.

Manitowoc County Cancer Officers Elected

The Manitowoc County unit of the American Cancer Society announced the appointment of *Dr. R. G. Strong* as president of the county chapter. Doctor Strong was also named as a delegate to represent the group at the annual society meeting at Milwaukee, October 13–14.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Doctor Joins Poser Clinic

Dr. Thomas Shearer has joined the Poser Clinic staff in Columbus. His brother, *Dr. Charles Shearer*, has been associated with the clinic for several years. They are the sons of *Dr.* and Mrs. *Floyd Shearer*, Edgerton.

Doctor Shearer recently completed his specialty training at the Ochsner Clinic in New Orleans, Louisiana, being in training with Dr. Alton Ochsner, professor of surgery at Tulane. After graduating from Northwestern University in 1950, he interned and had surgical residency at St. Luke's Hospital, Chicago, until 1952. He spent 1952–53 in Korea as a Captain in the Medical Corps. Returning to the states in 1954, he specialized in obstetrics at Camp Atterbury Hospital before going to New Orleans. He studied abdominal and chest surgery at the Ochsner Clinic, and in Columbus he will include obstetrics with his surgical practice.

Dr. Brei Assumes New Position

Dr. Frederick A. Brei of Oshkosh has assumed the position of Assistant Medical Director for the Aid Association for Lutherans at its home office in Appleton. Doctor Brei is a 1950 graduate of the Marquette University School of Medicine. He served his internship at Mercy Hospital in Oshkosh, and continued in general practice there until accepting the A. A. L. appointment. Doctor and Mrs. Brei and their son, Charles, will reside in Appleton.

Superior Gets New Doctor

A physician and surgeon who recently practiced in Akron and Youngstown, Ohio, Dr. John W. Foderick, has opened an office in Superior. Being a native of Canada, Doctor Foderick graduated from medical school at the University of Western Ontario and interned in Toronto. While in Ohio he took additional training in surgery.

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"While some of the tranquilizers are only partially effective as far as antiallergic activities are concerned . . . [hydroxyzine] has been found, by comparison, to be the most potent thus far . . ."[1]

"The most striking results were seen in those patients with chronic urticaria of undetermined etiology."[2]

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PSYCHOTHERAPEUTIC POTENCY for the relief of anxiety and tension.

The psychotherapeutic effectiveness of hydroxyzine (VISTARIL) was confirmed in a series of 479 patients suffering from a wide variety of dermatoses, including atopic dermatitis, neurodermatitis, psoriasis, lichen planus, nummular eczema, dyshidrosis, pruritus ani and vulvae, and rosacea. "Adverse reactions were minimal."[3]

RECOMMENDED ORAL DOSAGE: *50 mg. q.i.d. initially; adjust according to individual response.*

VISTARIL Capsules: *25 mg., 50 mg., 100 mg.*

VISTARIL Parenteral Solution: *10 cc. vials and 2 cc. Steraject® Cartridges. Each cc. contains 25 mg. hydroxyzine (as the HCl).*

REFERENCES:
1. Eisenberg, B. C.: Clinical Medicine *5*:897-904 (July) 1958.
2. Feinberg, A. R., et al.: J. Allergy *29*:358 (July) 1958.
3. Robinson, H. M., et al.: So. Med. J. *50*:1282 (Oct.) 1957.

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your broad-spectrum antibiotic of first resort

effective against more than 30 common pathogens, even including resistant staphylococci.

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Panmycin phosphate (tetracycline phosphate complex) equivalent to tetracycline hydrochloride . . . . . 250 mg.
Albamycin (as novobiocin sodium) . . . 125 mg.

2. Panalba KM †† Flavored Granules. When sufficient water is added to fill the bottle, each teaspoonful (5 cc.) contains:

Panmycin (tetracycline) equivalent to tetracycline hydrochloride . . . . . 125 mg.
Albamycin (as novobiocin calcium) 62.5 mg.
Potassium metaphosphate 100 mg.

Dosage:

Panalba Capsules
Usual adult dosage is 2 capsules q.i.d.

Panalba KM Granules
For the treatment of moderately acute infections in infants and children, the recommended dosage is 1 teaspoonful per 15 to 20 lbs. of body weight per day, administered in 2 to 4 equal doses. Severe or prolonged infections require higher doses. Dosage for adults is 2 to 4 teaspoonfuls 3 or 4 times daily, depending on the type and severity of the infection.

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Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: Each tablet contains 400 mg. meprobamate and 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl).

Supplied: Bottles of 50 scored tablets.

1. Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J. A. M. A. 166: 1019, March 1, 1958. 2. Current personal communications; in the files of Wallace Laboratories.

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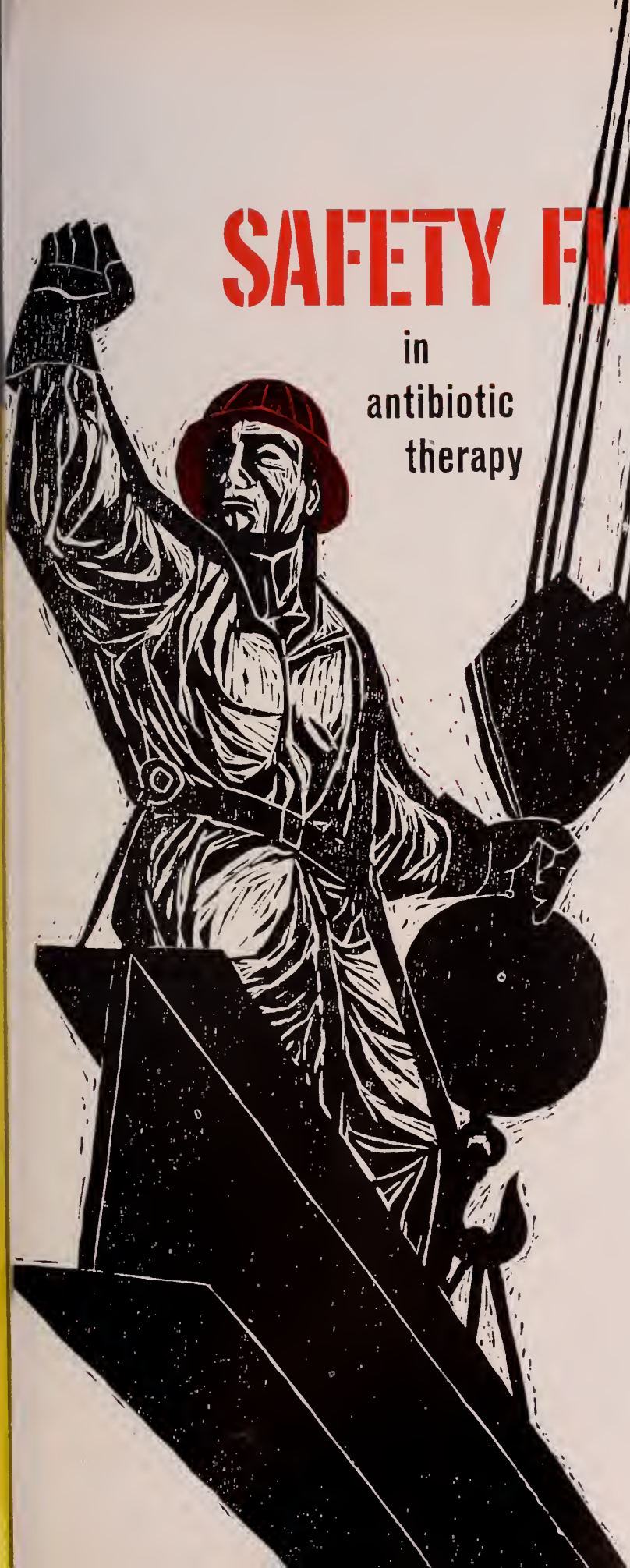
in antibiotic therapy



remarkable effectiveness against the cocci– plus a safety record unmatched in systemic antibiotic therapy

Now, after more than six years of extensive use, there has not been a single serious reaction to ERYTHROCIN. Additionally, the often-met problem of resistance has remained unusually low with ERYTHROCIN.

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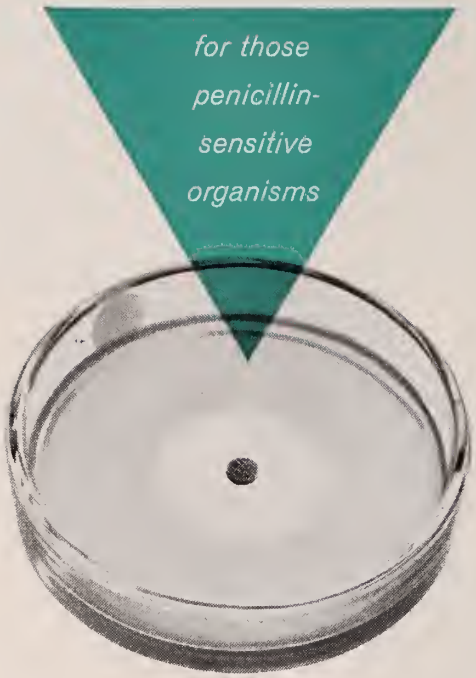

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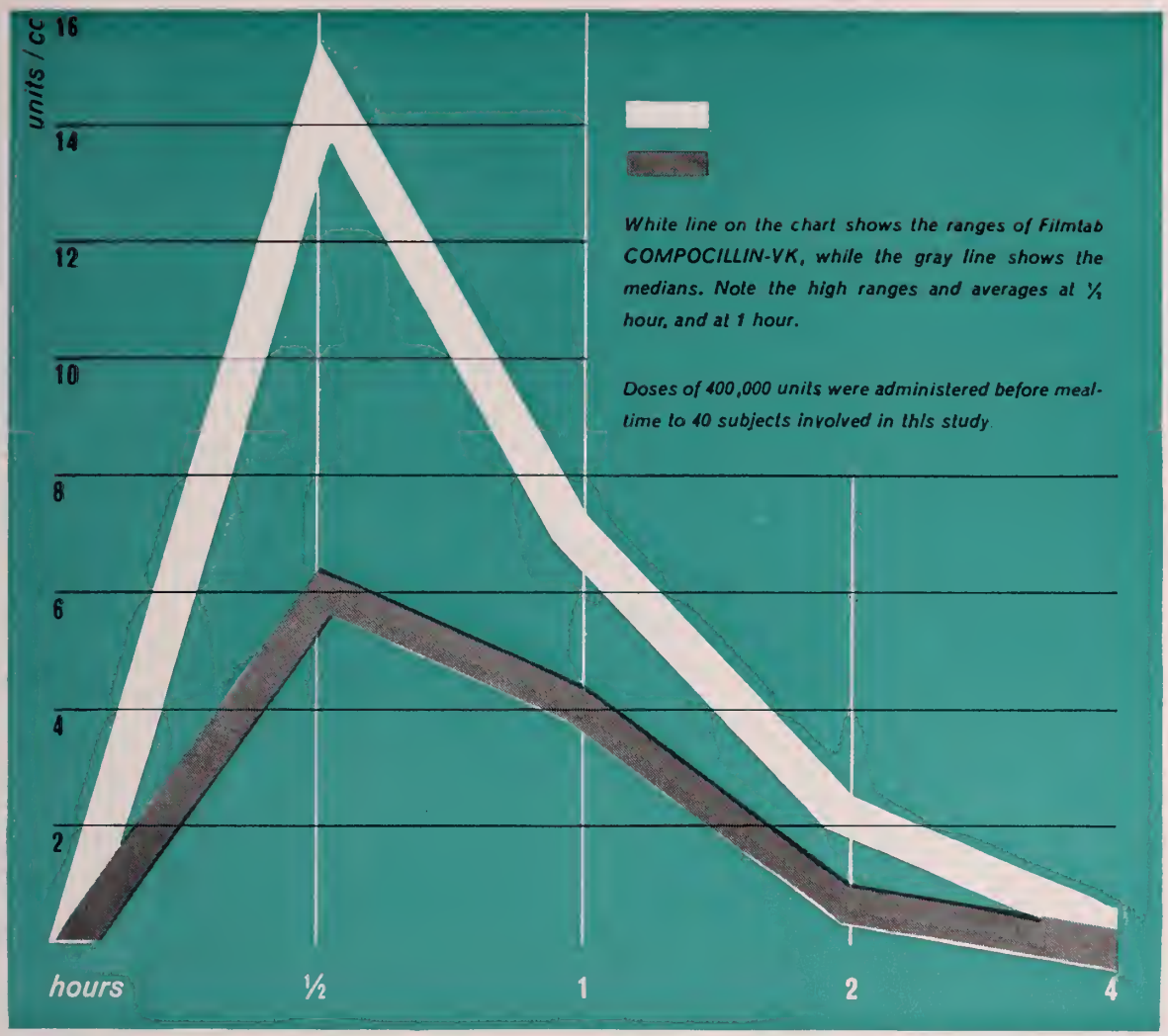

Now, in both Filmtab and Oral Solution, patients get high penicillin V blood levels with Compocillin-VK. Note the chart. Concentrations are three times higher than an equivalent dose of potassium penicillin G.

Compocillin-VK is indicated whenever you desire oral penicillin therapy. In severe infections, oral penicillin should be supplemented by parenteral therapy to obtain the maximum therapeutic response.

Indications:

Against all organisms sensitive to oral penicillin therapy. For prophylaxis and treatment of complications in viral conditions. And as a prophylaxis in rheumatic fever and rheumatic heart disease.

Dosage:

Depending on the severity of the infection, the usual adult dose is 125 to 250 mg. (200,000 to 400,000 units) every four to six hours. For children, dosage may be reduced in proportion to body weight.

Supplied:

In Filmtabs, representing 125 mg. (200,000 units) of potassium penicillin V, bottles of 50 and 100. In 250 mg. (400,000 units), bottles of 25 and 100.

For Oral Solution, Compocillin-VK comes in dry granules for easy reconstitution with water. Cherry-flavored, the granules come in 40-cc. and 80-cc. bottles. Each 5-cc. teaspoon of solution represents 125 mg. (200,000 units) of potassium penicillin V.

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Provides Outstanding Clinical Effectiveness Against Coccal Infections, Including Resistant Staphylococci and Enterococci[1]

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Provides Successful Short-Term Therapy In Endocarditis[2]

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Six papers presented at the Antibiotics Symposium[1] reported the effectiveness of SPONTIN against resistant staphylococcal infections. Clinical reponses involved enterococcal endocarditis, staphylococcal pneumonias and staphylococcal bacteremias. Many of these patients were going downhill steadily—in spite of treatment by other antibiotics.

Toxicity? Careful attention to dosage recommendations has practically eliminated toxicity and side effects as serious obstacles to therapy. Also, recent improvements have been made in the manufacture of SPONTIN; the drug is now made from pure crystals. A recent report[3] in the Journal of the American Medical Association concluded, "It is our opinion that, if proper precautions are observed, ristocetin is a safe and potent agent to employ in the treatment of staphylococcal infections."

If you do not have the revised literature on this lifesaving antibiotic, please contact your Abbott Representative soon; or write direct to Abbott Laboratories, North Chicago, Illinois.

INDICATIONS: Against a wide range of staphylococcal, streptococcal, pneumococcal and enterococcal infections. A drug of choice for treating serious infections, particularly those caused by organisms that resist all other antibiotics.

DOSAGE: Administered intravenously. In pneumococcal, streptococcal and enterococcal infections, a dosage of 25 mg./Kg. will usually be adequate. Majority of staphylococcal infections will be controlled by 25 to 50 mg./Kg. per day. It is recommended that the daily dosages be divided into two or three equal parts at eight- or 12-hour intervals.

SUPPLIED: In vials containing a sterile, lyophilized powder, representing 500 mg. of ristocetin A activity.
Be sure your hospital has it stocked.

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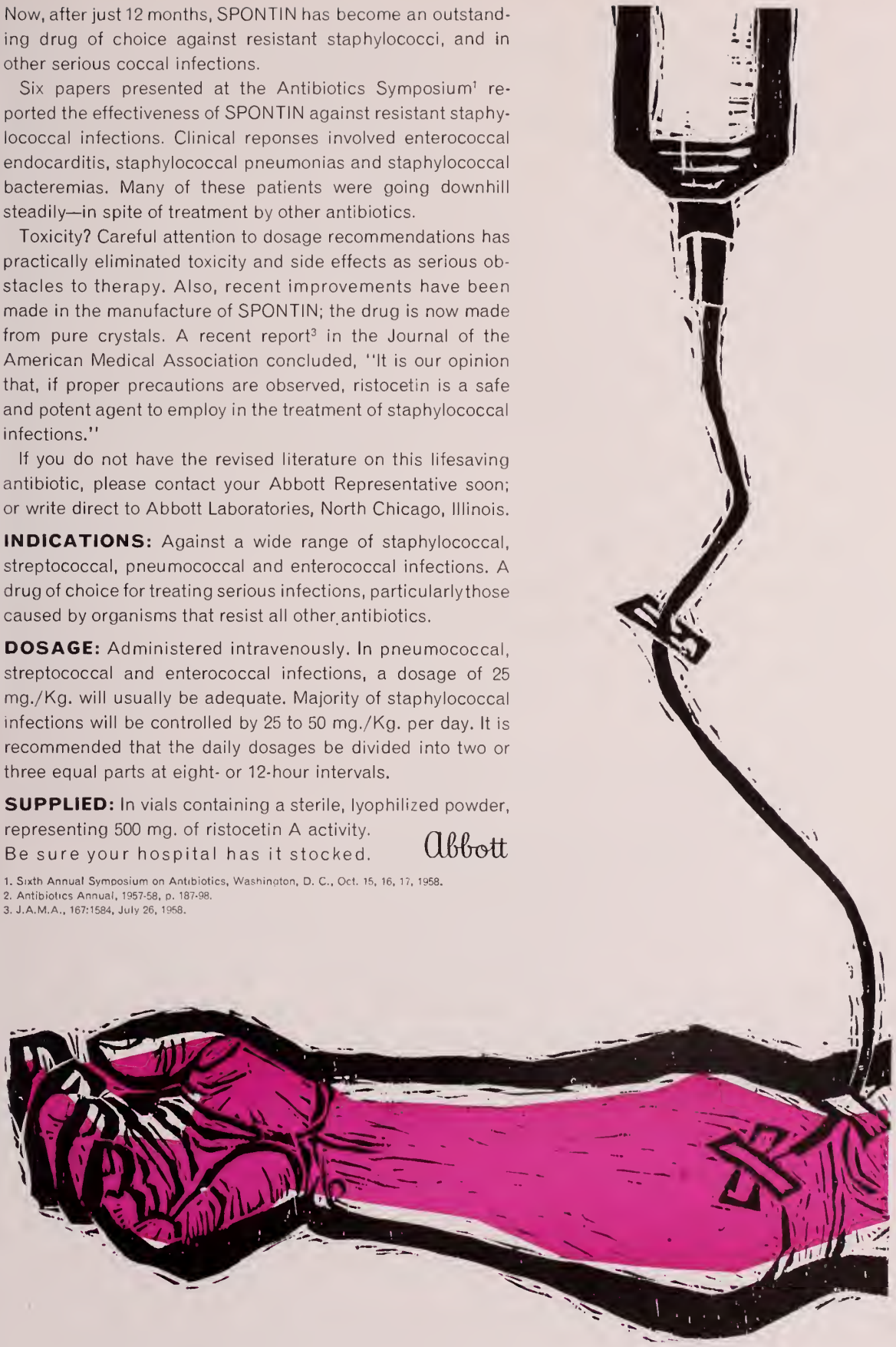
1. Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 15, 16, 17, 1958.
2. Antibiotics Annual, 1957-58, p. 187-98.
3. J.A.M.A., 167:1584, July 26, 1958.



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Fractures & Traumatic Surgery, Two Weeks, March 9
Treatment of Varicose Veins, Two Days, February 2, March 2
American Board Review Courses, Two Weeks, April 6
Blood Vessel Surgery, One Week, March 2
Gallbladder Surgery, Three Days, March 30
Surgery of Hernia, Three Days, April 2

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, Two Weeks, February 9, March 16
Vaginal Approach to Pelvic Surgery, One Week, February 2, March 9
General & Surgical Obstetrics, Two Weeks, February 23, March 30

MEDICINE—Electrocardiography, Two-Week Basic Course, March 16
Gastroscopy & Gastroenterology, Two Weeks, March 2
American Board Review Course, One Week, April 20

UROLOGY—Two-Week Intensive Course, March 30
Ten-Day Practical Course in Cystoscopy, by appointment

RADIOLOGY—Diagnostic X-Ray, Two Weeks, March 2, April 27
Clinical Uses of Radioisotopes, Two Weeks, May 4

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Four Physicians Begin Practice at La Crosse

Four physicians have recently affiliated themselves with the hospital medical staff of St. Francis Hospital, La Crosse. They are *Drs. Ruth M. Dalton,* George B. Ellenz, Albert L. Fisher, and *Edward C. Voss.*

Doctor Dalton completed her residency in pathology at Philadelphia General Hospital this year. She completed her medical education at the University of Illinois in 1953. She came to St. Francis on Sept. 4. Doctor Dalton will be associated with *Dr. Paul C. Dietz* in the practice of pathology.

Doctor Ellenz has been associated with *Dr. P. V. Hulick* in the x-ray department at St. Francis since early July. He is a native resident of La Crosse. He received his medical degree, cum laude, as valedictorian from Loyola Medical School, Chicago, in 1951.

Doctor Fisher, a former staff psychiatrist with the Veterans Administration hospital, Tomah, will continue in his professional specialty at St. Francis. He received his degree in medicine from the University of Wisconsin medical school in 1950.

Doctor Voss comes to La Crosse from a position as instructor in general surgery at the University of Iowa. He is a member of the La Crosse clinic. Doctor Voss received his degree in medicine from the University of Buffalo, Buffalo, New York, in 1950.

Annual Clinical Conference

CHICAGO MEDICAL SOCIETY

MARCH 2, 3, 4 and 5, 1959

Palmer House, Chicago

Daily Half-Hour Lectures by Outstanding Teachers and Speakers on subjects of interest to both general practitioner and specialist

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Scientific Exhibits worthy of real study and helpful and time-saving Technical Exhibits

The Chicago Medical Society Annual Clinical Conference should be a MUST on the calendar of every physician. Plan now to attend and make your reservation at the Palmer House.

THIRD AND TWELFTH DISTRICTS NEWS

Address by Doctor Crumpton

"Acute Pulmonary Hypertension—Pulmonary Embolism and Infarction" was the topic chosen by *Dr. C. W. Crumpton* for his lecture presented October 14 at a postgraduate course in Clinical Cardiopulmonary Physiology sponsored by the American College of Chest Surgeons in Chicago. Doctor Crumpton is associated with the Medicine-Cardiovascular Laboratory at the University of Wisconsin.

Doctor Pleyte Honored

Dr. A. A. Pleyte, Milwaukee, was awarded the 1958 Dearholt Medal for distinguished service in tuberculosis control at the annual meeting of the Mississippi Valley Conference on Tuberculosis at Dayton, Ohio, on October 16.

The medal, given annually, is named for Dr. Hoyt E. Dearholt, founder of the Wisconsin Anti-Tuberculosis Association and nationally known leader in TB control.

Doctor Pleyte has served as medical consultant to many Wisconsin sanatoriums including Hickory Grove Sanatorium of Brown County.

Gastroenterologists Elect Dr. Shaiken

Dr. Joseph Shaiken, Milwaukee, associate professor of clinical medicine, Marquette University School of Medicine, has been chosen as President-Elect of the American College of Gastroenterology at the annual meeting of the College, held Sunday, October 19, in New Orleans, Louisiana. He will assume the Presidency at the annual meeting to be held in Los Angeles, California, in September of 1959.

Doctor Shaiken

Dr. Brown on Research Project

Dr. Henry Brown, Department of Surgery at the University Hospitals, Madison, is spending October 18 to December 18 at the Hormone Research Laboratory of the University of California in Berkeley. He is studying the methods of peptide synthesis and degradation with Professor C. H. Li in connection with their work on the structure of hemoglobin.

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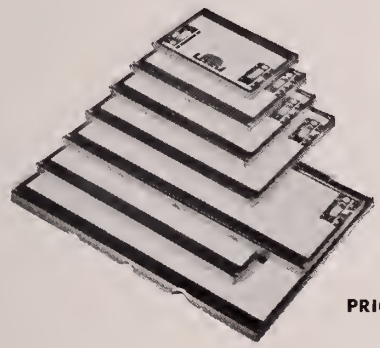

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CAPSULES
(black and white)
250 mg., 125 mg.
(for pediatric or long-term therapy)

ORAL SUSPENSION
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NEW! PEDIATRIC DROPS
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glucosamine-potentiated tetracycline with nystatin

Antibacterial plus added protection against monilial super-infection

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COSA-TETRACYDIN*

glucosamine-potentiated tetracycline-analgesic-antihistamine compound

For relief of symptoms and malaise of the common cold and prevention of secondary complications

CAPSULES (black and orange)—each capsule contains: Cosa-Tetracyn 125 mg.; phenacetin 120 mg.; caffeine 30 mg.; salicylamide 150 mg.; buclizine HCl 15 mg.

REFERENCES: 1. Carlozzi, M.: Antibiotic Med. & Clin. Therapy 5:146 (Feb.) 1958. 2. Welch, H.; Wright, W. W., and Staffa, A. W.: Antibiotic Med. & Clin. Therapy 5:52 (Jan.) 1958. 3. Marlow, A. A., and Bartlett, G. R.: Glucosamine and leukemia, Proc. Soc. Exp. Biol. & Med. 84:41, 1953. 4. Shalowitz, M.: Clin. Rev. 1:25 (April) 1958. 5. Nathan, L. A.: Arch. Pediat. 75:251 (June) 1958. 6. Cornbleet, T.; Chesrow, E., and Barsky, S.: Antibiotic Med. & Clin. Therapy 5:328 (May) 1958. 7. Stone, M. L.; Sedlis, A., Bamford, J., and Bradley, W.: Antibiotic Med. & Clin. Therapy 5:322 (May) 1958. 8. Harris, H.: Clin. Rev. 1:15 (July) 1958.

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Madison Doctors Attend Meeting

The meetings of the Academy of Otolaryngology held at the Palmer House in Chicago, October 12–18, were attended by three staff members of the University of Wisconsin Medical School, *Drs. C. R. Taborsky, E. M. Bennett,* and *R. D. Lange.* During the week preceding the scientific meeting Doctor Lange appeared before the Board of Otolaryngology and was accepted as a Diplomate of that American Board of Otolaryngology.

Medical Colleges Hold Meeting

During the week of October 11 *Drs. O. A. Mortensen, J. Z. Bowers* and *R. C. Parkin,* all of the University of Wisconsin, went to Philadelphia for the annual meeting of the Association of American Medical Colleges. As a participant in the program, Doctor Parkin discussed the results of the recent two-year study of the Wisconsin preceptorship program.

Receives Grant Easter Seals

The University of Wisconsin recently received a grant of $2,288 for "Growth and Development of Basic Motor Skills" from the Easter Seal Research Foundation. Members of the team at the University will analyze selected growth data obtained from children to develop an approach to studying the evolution of mature movement patterns.

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Open Offices in Shopping Center

Offices were opened in the new County Fair Shopping Center in Milwaukee by Drs. Ralph F. Sortor and Raymond D. Hill, who will specialize in obstetrics and gynecology.

A native of Canada, Doctor Hill received his medical degree from McGill University in 1954, interned at Grace Hospital, Detroit, the following year, and from 1955–1958 served a residency in obstetrics and gynecology at that hospital. He was chief resident in his final year.

Doctor Sortor also studied at McGill University, obtaining his degree in 1953. Following a year of internship in Buffalo, New York, and a year of postgraduate training in general surgery in Baltimore, Maryland, Doctor Sortor took three years training in his speciality at the City of Detroit Receiving Hospital.

Medical Center Officers Named

The Janesville Medical Center chose its officers at the annual meeting of the corporation in the Fall. The physicians elected are: Drs. *J. J. Tordoff*, president; *Arthur Reinardy*, second vice-president; and *Everett Reinardy*, outgoing president, member of the board of directors. Several nonmedical, professional persons constitute the balance of the posts.

Postgraduate Course Held at UW

A program entitled, "Recent Advances in Anesthesia and Resuscitation," was the first in a series of five postgraduate courses for physicians sponsored by the University of Wisconsin Medical School. The sessions held October 10–11 featured guest speaker, Dr. John E. Stienhaus, chairman of the anesthesiology department at Emory University, Atlanta, and eight UW doctors in the fields of surgery, neurosurgery, and anesthesiology—*Drs. O. S. Orth, B. J. Bamforth*, R. S. Barreto, *Richard Botham, Manucher Javid, Karl L. Siebecker*, John F. Tench and *William P. Young*.

Jackson Clinic Adds New Member

It was recently announced that *Dr. Gordon F. Schumacher* has joined the staff of the Jackson Clinic, Madison, in the department of obstetrics and gynecology. Prior to locating in Madison, Doctor Schumacher was associated with the State University of Iowa.

A 1954 graduate of Marquette University, he interned at Queen of Angels Hospital in Los Angeles and served a three-year residency at the University of Iowa. Doctor Schumacher is a junior fellow in the American College of Obstetricians and Gynecologists.

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Hubert H. Blanchard, M. D.
John E. Leach, M. D.
Lloyd F. Jenk, M. D.
Richard O. Barnes, M. D.
John R. Whitty, M. D.

Preston W. Thomas, M. D.

THE RATIONALE FOR THE USE OF VITAMINS IN FORESTALLING INFECTIONS

Many clinicians believe that good nutrition plays a significant role in preventing bacterial infections, and that immunity depends on adequate vitamin levels. Tisdall[1] states that "a low intake of a number of vitamins, a low intake of minerals, and a change in the quality of protein can all lower resistance to infection."

Other studies show the important role of the B vitamins in antibody formation. Thus, *Nutrition Reviews*[2] reports: "Present evidence indicates that certain B vitamins, notably pyridoxine, pantothenic acid and folacin, play a significant role in antibody synthesis." According to Pollack and Halpern,[3] "Under-nutrition leads to increased susceptibility to infection and decreased resistance to established disease." And "vitamin deficiency states also may adversely influence circulating antibodies."

Halpern[4] reports that "good nutrition is important for optimal resistance to infection, for a superior tissue capability to cope with disease and injury, and for maximum antibody production . . . nutrition participates in the prophylaxis against most acute infections . . ."

And while MacBryde[5] feels that evidence is lacking to support the view that a higher than normal intake of vitamins will improve resistance to infection, he also states: "Restoration of nutrition to normal exerts a favorable influence on practically all disease conditions . . . Often the outcome will depend more upon the correction of the malnutrition than upon any therapy directed toward the malady."

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References: 1. Tisdall, F. F.: Clinical Nutrition, ed. by Joliffe, N.; Tisdall, F. F., and Cannon, P. R.: Paul B. Hoeber, Inc., New York, 1950, p. 748. 2. Nutrition Reviews, *15*:47, (Feb.) 1957. 3. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 18. 4. Halpern, S. L.: Ann. N. Y. Acad. Science *63*:147, (Oct. 28) 1955. 5. MacBryde, C. N.: Signs and Symptoms, J. B. Lippincott Co., Phila., 3rd Ed. 1957, p. 818.

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Missouri Doctor in Beloit

Having recently been released from military service, Dr. Gilpin C. Matthews is now associated with *Dr. D. M. Clark* in Beloit. Doctor Matthews received his medical degree from Washington University before serving as a surgeon in the U.S. Air Force. He was stationed in Kansas City, Missouri.

Take Cancer Chemotherapy Course

Drs. J. M. Schroeder and *F. J. Ansfield*, Cancer Research Department, University of Wisconsin Medical School, attended a course in cancer chemotherapy in New York at the end of October.

Has Article Published

The current issue of the JOURNAL OF PLASTIC AND RECONSTRUCTIVE SURGERY contains an article by *Dr. Frank D. Bernard* entitled "Dermabrasion Tattooing." Doctor Bernard is associate clinical professor of surgery at the University of Wisconsin Medical School.

Speaks at Anesthesiology Meeting

Dr. O. Sidney Orth, Department of Anesthesiology, University of Wisconsin Medical School, was a guest speaker at the meeting of the Illinois Society of Anesthesiology held in Peoria, Illinois, on October 4.

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Marquette University Host to College Health Conference

"Action for Health in Wisconsin Colleges" was the theme for the College Health Conference held October 10 and 11 at Marquette University, Milwaukee. Objectives of the conference were to determine the scope of the college health program and to find out who should be concerned with it; to provide an opportunity for college and university personnel concerned with student health to identify and discuss mutual problems; and to provide assistance to college and university staffs in finding ways of meeting and resolving some of the common problems in college health programs.

Keynote address was given by Dr. Ralph I. Canuteson on "Major Issues in College Health which Must Be Resolved". Doctor Canuteson is Director of Student Health Service, University of Kansas, Lawrence, Kansas.

Wisconsin physicians who participated in the program are: *Dr. John S. Hirschboeck*, Dean, Marquette University School of Medicine, Milwaukee; *Dr. O. B. Rowlands*, Director, Student Health Service, University of Wisconsin–Milwaukee; *Dr. W. D. Stovall*, Madison, Wisconsin State Board of Health; *Dr. Paul J. Lawler*, Marquette University School of Medicine, Milwaukee; *Dr. Mary Broadbent*, Wisconsin Anti-Tuberculosis Association; *Dr. Paul LaBissioniere*, Marquette University; *Dr. E. B. Pfefferkorn*, Wisconsin State College, Oshkosh; and *Dr. M. W. Stuessy*, Brodhead.

Completes Special Study Tour

Dr. Hans H. Reese, associate professor in the department of neurology, University of Wisconsin Medical School, was a guest of the Federal Republic of Germany for a special study tour to German Universities including Berlin (West). Doctor Reese was one of eight participating guests in the study group which included physicians from California, Kansas, Minnesota, Nevada, New York, Pennsylvania, Texas and Wisconsin. The group left New York on November 2 and returned December 2 via Lufthansa. The program was prepared by the Public Health Division of the German Federal Ministry of the Interior at Bonn. It included among special subjects undergraduate and postgraduate medical education and trends of researches in medicine.

Doctor Samp Talks

In October the Eau Claire Exchange Club heard *Dr. Robert Samp* speak on the facts of life pertaining to cancer prevention at its luncheon meeting. Doctor Samp holds a position on the Cancer Research Staff at the University of Wisconsin.

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OBITUARIES

Dr. F. X. Pomainville, one of Wisconsin's oldest practicing physicians, died September 1 at the age of 87. He had been actively practicing at Wisconsin Rapids since 1899.

Doctor Pomainville was born in 1871 at Wisconsin Rapids. He graduated from Rush Medical College in 1899 and returned to his home-town to set up practice. During World War I he served in the Medical Corps, being stationed in France.

Throughout his career, Doctor Pomainville was active in community affairs, serving as mayor, as a member of the Board of Education, and as city health officer for more than 40 years. He held the positions of chief-of-staff at Riverview Hospital, attending physician at the Wood County Infirmary, company surgeon with the Milwaukee Road, and local surgeon with the Chicago and Northwestern Railroad.

He was very active in the American Legion and served as commander of the local post; he also was active in the Veterans of Foreign Wars in Wisconsin Rapids, and was the State Medicin of the Forty and Eight.

Doctor Pomainville was a life member of the State Medical Society of Wisconsin and was made a member of its Fifty Year Club. He was a member of the Wood County Medical Society, having held the offices of president and secretary; the American Medical Association; and the American Association of Railway Surgeons. In 1956 he received a citation of merit from the State Society in tribute to his devotion to the health of mankind and participation in civic matters.

Surviving are three daughters, Janet Pomainville, Milwaukee; Mrs. Margaret P. Lathrop, Richmond, Virginia; and Mrs. Paul Pratt, Greenwich, Connecticut; and two physician nephews, Drs. L. C. and Harold Pomainville, both of Wisconsin Rapids. His brother, Dr. George Pomainville passed away in 1943, and his son, Dr. Francis Pomainville, in 1944.

Dr. B. J. Steves, formerly of Menomonie, passed away September 8 at Fort Dodge, Iowa, He was 84 years of age.

Doctor Steves was born at Louisville in 1874, graduated from the Chicago Homeopathic Medical College in 1903 and interned at that school the following year. He opened his first practice in Menomonie in 1904, leaving in 1907 for one year to attend Northwestern University Medical School. Upon completion of this additional training Doctor Steves returned to Menomonie where he practiced until ill health forced him into retirement in 1952. The community honored the doctor last spring when he and his wife moved to a Fort Dodge home for retired people.

He was a member of the Eau Claire–Dunn–Pepin County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Besides his widow, Minnie, a son, Dr. Richard J., a dermatologist in Des Moines, Iowa, survives.

Dr. J. W. Goggins, a physician in Chilton for more than 30 years, died September 16 after a lingering illness.

He was born in Calumet County in 1880. Doctor Goggins was a 1910 graduate of the Milwaukee College of Physicians and Surgeons and spent his first three years in practice at Royalton. He then moved to Calumetville and located in Chilton during 1921. He retired in 1957 because of ill health.

Doctor Goggins was a member of the Calumet County Medical Society for which he served terms as president, secretary, and delegate to the State Society. He was also a member of the State Medical Society of Wisconsin and the American Medical Association.

Survivors include two brothers and five sisters.

Dr. F. B. Taylor, of Madison, passed away September 25 in a local nursing home after a long illness. He was 79 years of age.

He was born at Boscobel in 1879. A 1904 graduate of the Chicago College of Physicians and Surgeons, which is now part of the University of Illinois, Doctor Taylor served his internship at West Side Hospital of Chicago. Prior to locating in Madison in 1916, he practiced at Troy Miles, Iowa, Mount Sterling and Lodi. In 1956 he entered retirement.

Doctor Taylor was affiliated with the Dane County Medical Society, being granted honorary membership in 1954 at which time the county praised his work as a general practitioner. He was also a member of the State Medical Society of Wisconsin, the American Medical Association, and became a member of the Fifty Year Club of the State Medical Society in 1954.

Survivors include his widow, Pearl, and three children.

Dr. S. N. Franklin, a retired Milwaukee general practitioner, died October 14 at the age of 76.

Doctor Franklin was born in Russia in 1881 and came to the United States when he was 20 years old. After receiving his medical degree from Marquette University in 1916, he began practice in Milwaukee. In 1942 he moved his office to West Allis where he remained until entering retirement a year ago.

He was a member of the State Medical Society of Wisconsin, The Medical Society of Milwaukee County, and the American Medical Association.

Surviving Doctor Franklin are his widow, Minnie; two daughters, Charlotte, New York City, and Mrs. Denora Black, Fox Point; and a brother, Dr. Isadore, a Milwaukee ophthalmologist.

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Dr. John A. Beyer, 37, a Madison cardiologist, died October 18 in an automobile accident in South Dakota while enroute to a scientific meeting of the American Heart Association in California.

Born at Dover, New Jersey, in 1921, Doctor Beyer received his medical education at Columbia University, graduating in 1945. He interned at New York Postgraduate Hospital, and served as an instructor at Columbia University School of Pharmacology. He was an American Heart Research Fellow at New York Hospital while he served under and was associated with the office of Cardiologist Irving S. Wright, M.D., New York City.

Doctor Beyer practiced at East Hampton, New York, for one year and was in military service in which he served as chief cardiologist at Percy Jones Army Hospital, Battle Creek Michigan, before joining the staff of Associated Physicians at Madison in 1953. In addition to his practice, he served as cardiologist at the Kiddie Camp Home and for the weekly rheumatic fever clinics sponsored by the Wisconsin Department of Crippled Children and held at St. Mary's Hospital. He was on the panel for the Wisconsin Heart Association mobile clinic and was consulting cardiologist to the Visiting Nurse Service. Doctor Beyer was a physician at the Oakwood Lutheran Home, Madison General and St. Mary's Hospitals. He was chairman of the records committee at Madison General Hospital.

Memberships held by Doctor Beyer included those with the Dane County Medical Society, the State Medical Society of Wisconsin, the American Medical Association, the American Heart Association, and the American Federation of Clinical Research. He also was an associate member of the American College of Physicians and certified by the American Board of Internal Medicine.

His widow and two sons survive.

Dr. W. P. O'Malley, a Milwaukee physician for 30 years, died October 28. He was 60 years of age.

He was born at Waunakee in 1898. Prior to entering the University of Wisconsin Medical School, from which he graduated in 1928, Doctor O'Malley served in the U.S. Army during World War I. He had been on the staff at Milwaukee Hospital since finishing an internship there in 1929.

Doctor O'Malley was a member of the State Medical Society of Wisconsin, the Medical Society of Milwaukee County, the American Medical Association, the Milwaukee Academy of Medicine, and the American Academy of General Practice.

He is survived by a daughter, Mrs. Ann Spoor, Brooklyn, New York; his mother, Mrs. J. R. O'Malley, Madison; a sister and four brothers.

Dr. M. W. Trentzsch died suddenly at his Highland home on October 29. He was 77 years of age.

Doctor Trentzsch had practiced in Highland since graduation from the University of Illinois Medical School in 1913.

Surviving are his widow, three daughters and a son.

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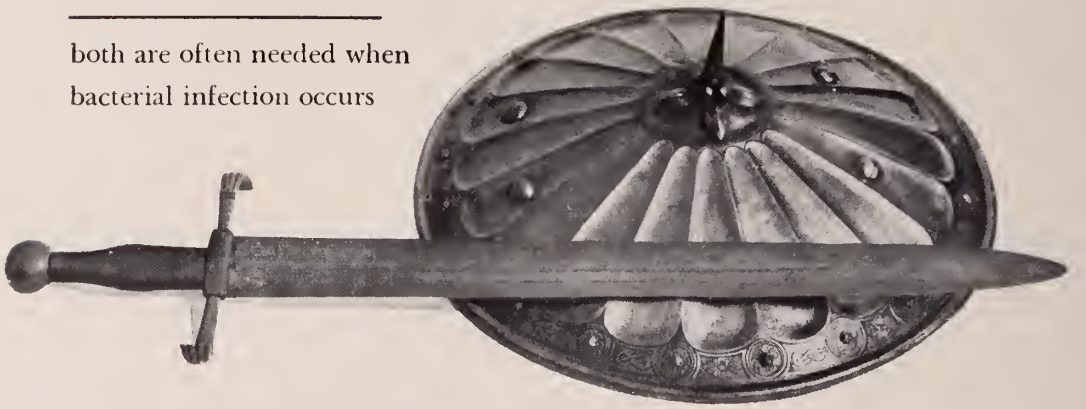

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R. B. Barrick, 414 East Walnut Street, Green Bay.

R. E. Johnston, Bellin Building, Green Bay.

B. F. Kalina, 130 East Walnut Street, Green Bay.

R. L. Johnson, Route #2, Friendship.

E. C. Voss, Jr., La Crosse Clinic, La Crosse.

K. J. Harrington, 216 Charles Drive, Menomonee Falls.

Change of Address

R. M. Newton, **Narrows, Virginia, to U. S. Army Hospital, Camp Leroy Johnson, New Orleans 40, Louisiana.

W. J. Boulet, Clintonville, to 5 West Rollin Street, Edgerton.

G. A. Stokdyk, Milwaukee, to Santa Cruz County Hospital, Santa Cruz, California.

J. J. Frederick, Cudahy, to 2868 South Kinnickinnic Avenue, Milwaukee.

T. D. Smith, Neenah, 5685 North Round Meadow Road, Calabasas, California.

H. N. Heinz, Taylors Falls, Minnesota, to 607 North 8th Street, Sheboygan.

O. F. Guenther, Campbellsport, to 721 Baldwin Avenue, Oshkosh.

J. W. Stackpole, Wausau, to 237 Loomis Street, Burlington, Vermont.

A. J. Herlitzka, Wausau, to 1316–4th Street, S.W., Mason City, Iowa.

Andrew Boyd, Jr., **Milwaukee, to Station Hospital, U.S.N. Submarine Base, New London, Connecticut.

A. T. Holbrook, Milwaukee, to 535 Edgewater Drive, Dunedin, Florida.

P. P. Foderick, Plum City, to Hallock, Minnesota.

V. R. Vanstane, Edgerton, to 1402 Lake View Avenue, Madison.

R. S. Vivian, Beloit, to 390–2nd Avenue, South, Naples, Florida.

R. L. MacCornack, Jr., Whitehall, to 1044–17th Avenue, North, South St. Paul, Minnesota.

R. E. Bolinske, Columbus, Ohio, to 1204 Francis Place, Richmond Heights, Missouri.

W. W. Stebbins, Madison, to 222-8th Avenue, North, St. Petersburg, Florida.

R. L. Demke, Elroy, to 116 Congress Street, Rushville, Illinois.

H. A. Devine, Fond du Lac, to Muskelange Lodge, Squirrel Lake, Minocqua.

C. A. Graf, Marshfield, to University Houses, Apartment 41–c, Madison.

G. T. Huckle, Marshfield, to 159 N.E. 5th Avenue, Delray Beach, Florida.

J. E. Hutchens, Waukesha, to 7074 West Beckett Avenue, Milwaukee.

L. V. Kempton, Burlington, to 179 Orchard Place, Villa Park, Illinois.

C. E. Mueller, Spooner, to 1205 Wise Avenue, Boscobel.

P. R. Noble, Marshfield, to Saginaw General Hospital, Saginaw, Michigan.

C. E. Ward, Appleton, to 15 West Central Avenue, Delaware, Ohio.

D. H. White, Jr., Madison, to 6920 Munsee Lane, Indianapolis, Indiana.

J. B. Toussaint, Chippewa Falls, to Central Wisconsin Colony, Madison.

R. M. Dalton, Philadelphia, Pennsylvania, to St. Francis Hospital, La Crosse.

M. J. Valaske, **Newport, Rhode Island, to NAS Cecil Field, %Medical Dispensary, Jacksonville, Florida.

Gordon Rumhoff, **APO 971, San Francisco, California, to Hq. & Hq. Company, 1st BC, 5th Cavalry, APO 24, San Francisco, California.

J. E. Schlichting, Sheboygan, 3039 West Ruskin Court, Milwaukee.

G. W. Poindexter, Wood, to 437 West North Avenue, Milwaukee.

E. C. Seno, Chicago, Illinois, to V. A. Hospital, Knoxville, Iowa.

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BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interests of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison 6, Wisconsin.

Clinical Obstetrics and Gynecology. Vol. I, No. 1. A Quarterly Book Series. Medical Problems in Pregnancy, edited by Curtis J. Lund, M.D. Management of Endocrine Problems, edited by Allan C. Barnes, M D. New York, Harper & Brothers, 1958. Subscription Price Per Year $18.00.

This is the first volume of a quarterly book series the purpose of which is to present to the busy, active clinician a source of information on the procedures used by experts at leading centers in the actual care of patients.

In this issue Dr. Curtis Lund is the guest editor of the obstetrical symposium on Medical Problems in Pregnancy. The problems discussed are: anaemia, heart disease, diabetes, disease of the adrenals, viral hepatitis, urinary tract infections, tuberculosis, poliomyelitis, and multiple sclerosis.

The guest editor of the gynecological symposium on the Management of Endocrine Problems is Dr. Allan C. Barnes. There is a preliminary discussion of the diagnostic aids and their value as related to endocrine function. The problems discussed include: amenorrhoea, dysfunctional uterine bleeding, dysmenorrhoea, the menopause, the endocrine treatment of sterility, threatened and habital abortion, diabetes in pregnancy, disturbance of lactation, and problems related to growth and sexual development.

The subject matter discussed presents the handling of the specific clinical problem. The material presented covers an area in obstetrical and gynecological literature not found in the textbooks or the current specialty journals.

These volumes will be of special interest to the clinician and the residents in training in obstetrics and gynecology.—*Madeline J. Thornton, M.D.*

Surgery in Infancy and Childhood. By Matthew White, M. A., M.B., Ch.B., F.R.F.P.S. (Glas.), F. R. C. S. (Edin.), Consulting Surgeon, Royal Hospital for Sick Children, Glasgow; and Wallace M. Dennison, M.D., F.R.F.P.S. (Glas.), F.R.C.S., (Edin.) F.I C.S., Surgeon, Royal Hospital for Sick Children, Glasgow, Paediatric Surgeon, Royal Maternity and Women's Hospital and Stobhill General Hospital, Glasgow. E. & S. Livingstone Ltd., Edinburgh and London (The Williams & Wilkins Co., Baltimore, exclusive U.S. agents.) 1958. 444 pages. Price $9.50.

This book is designed to introduce the senior medical students to some of the surgical problems encountered in infancy and childhood. It represents material presented in the 10 weeks' course of problems of surgery in infancy and childhood in the final year at the Glasgow Medical School.

As one reads through the text, one is impressed by the fine descriptive terminology in the clinical syndromes and with the excellent illustrations, many of them in color.

As stated in Chapter 1, pediatric surgery is not a special branch of surgery but is the whole of surgery applied to a special age group. Many of the disease entities discussed in this volume are well covered but the attempt to condense all of pediatric surgery into this book, often results in a very brief description of the disease, particularly in regard to treatment.

I believe that this book fulfills the purpose for which it was written as an introduction to surgery in infancy and childhood for medical students, and it also may serve as a handy reference volume for the practicing physician.—*Kenneth E. Lemmer, M.D.*

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The Atomic Age and Our Biological Future. By H. B. Bronsted. Philosophical Library, Inc., New York, N.Y.

This small volume deals with the threat of radiation to the future of man. It is written in a popular style with the apparent assumption that the reader has no prior knowledge of either biology or radiation. An effort is made in the first of ten chapters to describe the origin and nature of ionizing radiation, and the manner in which it affects matter. The remaining chapters are largely concerned with the biological effects of radiation with appropriate emphasis on genetics. The presentation of certain technical details is regrettably not entirely lucid, particularly those which deal with radiation physics.

However, the author should be successful in accomplishing his aim of informing broad sections of the population of the risk to which we expose mankind in having recourse to atomic energy in our struggle for existence.—*Frank C. Larson, M.D.*

The Preservation of Youth. By Moses benMaimonides (Maimonides). New York, Philosophical Library, Inc., 1958. Price $2.75.

This little book about the physical and mental aches of His Royal Honorable Highness, the Sultan, reads like a delightful and amusing tale. It stems from one of the most colorful personalities of the 12th century Arab World, Maimonides, and the Jew from Cordoba, who was an eminent physician and philosopher.—K. A.

NEW BOOKS RECEIVED

Pye's Surgical Handicraft. Edited by Hamilton Bailey, F.R.C.S. (Eng.), F.A.C.S., F.R.S. (Edin.), Emeritus Surgeon, Royal Northern Hospital, London; General Surgeon, Metropolitan Ear, Nose, and Throat Hospital; Consulting Surgeon, Italian Hospital. The Williams & Wilkins Company, Baltimore. 17th Edition. 1956. 800 pages. Price $10.00.

Rehabilitation After Illness and Accident. Edited by Thomas M. Ling, M.D., M.R.C.P., Consultant Psychiatrist to the Marlborough Day Hospital; and C. J. S. O'Malley, C.B.E., M.B., Medical Director, Camden Road Rehabilitation Center; Consultant in Physical Medicine, Queen Mary's Hospital, Roehampton. Bailliere, Tindall and Cox, London (The Williams & Wilkins Co., Baltimore, exclusive U.S. agents). 1958. 119 pages. Price $3.50.

Prenatal Facts

SUGGESTED PROCEDURE } **File at hospital in last month of pregnancy. If there are indications of possible premature delivery file earlier. Direct this form to the supervisor of obstetrics of the hospital to which the patient will be admitted.**

Name _____ **Address** _____ **igion** _____

Expected date of confinement _____ _____ **Para** _____

Number of abortions _____ **miscarria** _____ **del.** _____

multiple birt'

Natu _____

Weig

Speci _____

Chest _____

Evaluati _____

Wasserma _____

Coombs te _____

Date of visi _____

Weight _____

Heart _____

FOR YOUR CONVENIENCE, DOCTOR . . .

The Division on Maternal and Child Welfare has prepared a sheet which is recommended for use by all Wisconsin physicians in reference to hospital care of obstetrical patients . . .

You will find this of convenience to you, and of much value to your obstetrical patients. It will alert the hospital to proper care when your patient is admitted for delivery.

Per pad of 100 forms—$2.00.

Write:
DIVISION ON MATERNAL AND CHILD WELFARE
State Medical Society of Wisconsin
Box 1109, Madison 1, Wisconsin

STATE MEDICAL SOCIETY OF WISCONSIN — MEDICINA NUSQUAM NON EST

"THE DOCTORS' PLAN"

THE BLUE SHIELD PLAN
OF THE
STATE MEDICAL SOCIETY OF WISCO

Facts about WISCONSIN PHYSICIANS SERVICE

PREPARED BY THE COMMISSION ON MEDICAL CARE PLANS

WPS–BLUE SHIELD GOES LOCAL

The unique concept of payment of the "customary, usual and reasonable" charge has been developed by Wisconsin Physicians Service and is available throughout the state (except in Milwaukee County) under the label of the "special service" contract.

About 428 groups covering nearly 58,175 persons are now insured. Employed groups of five or more persons may enroll. No-fee-schedules or income limits are involved in the contract.

Most significant, however, is the fact that the "special service" contract is the first instance in Wisconsin in which the county medical society—the local profession—actually and directly becomes involved in the settlement of claims and the administration of the program. The concept that Blue Shield is "The Doctors' Plan" is now completely true in the local sense. Under the "special service" contract the county society assumes its rightful role as counselor, fact-finder, arbiter and reporter in handling Blue Shield claims at the place where they are incurred.

The "special service" contract provides that most benefits will be paid to the extent of the physicians' customary, usual and reasonable charges. A charge will be deemed customary, usual and reasonable if it does not exceed the general level of charges by others who render such services or dispense such materials under similar or comparable circumstances within the community in which the charge is incurred.

WPS–Blue Shield expects that physicians submitting claims for patients holding the "special service" contract will do so on the basis of their usual charges, considering the patient's medical condition, the scope of service rendered, skill required, length of period of care, income, age, etc. Processing of claims on this basis of necessity requires a complete description of services rendered.

Where the "special service" contract is sold the county medical society is asked to form an insurance advisory committee to assist the WPS–Blue Shield office in the evaluation of claims. The vast majority of claims can be processed promptly by the WPS–Blue Shield office. Those involving unusual service, complicated and prolonged care or involved circumstances may require referral to the county advisory committee. Referral of such a claim does not imply that it is "unreasonable" or that it contains elements of overcharge. Ordinarily, such claims simply require more serious consideration to assure adequate and fair settlement. Some need added description and explanation from the physician in charge before proper payment can be made.

Among the elements ordinarily considered in determining the customary, usual and reasonable charge are:

1. The difficulty of rendering the services.
2. Skill required in the performance of the services.
3. The experience and skill of the person furnishing the service.
4. The range for charges for such services under all circumstances.
5. Any agreements as to charges which might have been made with the patient.
6. The necessity for consultants or assistants.
7. The necessity as to type and extent of laboratory work.
8. The necessity of medications, x-rays and prosthetic devices.
9. The financial ability of the patient to pay.
10. The general level of similar charges for services or materials in the community or area in which the charge is incurred.

These are factors which can best be evaluated by the county society among its own members. That is why WPS–Blue Shield is in effect developing county Blue Shield plans throughout Wisconsin.

FOR INFORMATION OR ADVICE

Write: 330 E. Lakeside, MADISON, WIS. Phone: ALpine 6–3101, MADISON, WI

Of course, *women like "Premarin"*

Therapy for the menopause syndrome should relieve not only the psychic instability attendant the condition, but the vasomotor instability of estrogen decline as well. Though they would have a hard time explaining it in such medical terms, this is the reason women like "Premarin."

Doctors, too, like "Premarin," because it really relieves the symptoms of the menopause. It doesn't just mask them — it replaces what the patient lacks — natural estrogen.

"PREMARIN"®
conjugated estrogens (equine)

Ayerst Laboratories • New York 16, New York • Montreal, Canada

5840

For Real Pain ...give real relief:

A.P.C. WITH Demerol®
tablets

Each tablet contains:

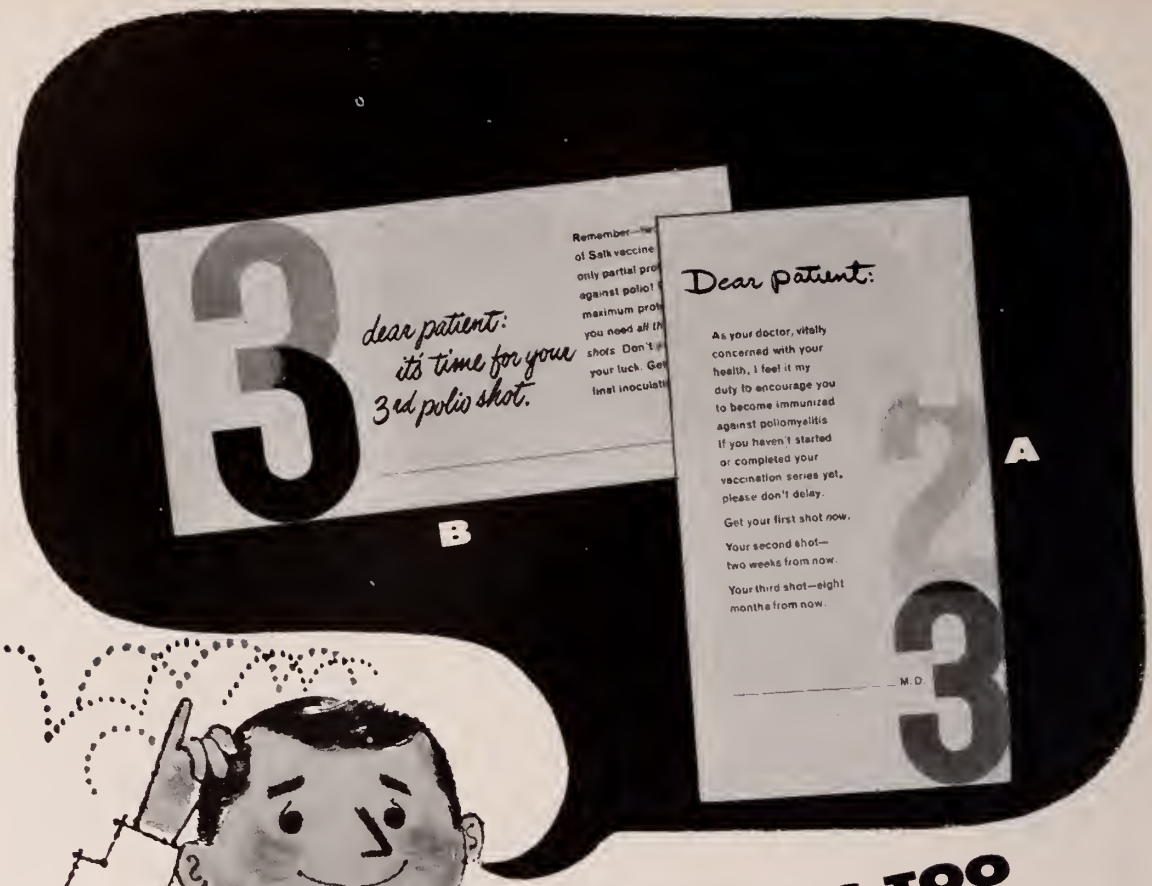
Aspirin	200 mg.	(3 grains)
Phenacetin	150 mg.	(2½ grains)
Caffeine	30 mg.	(½ grain)
Demerol hydrochloride	30 mg.	(½ grain)

Average Dose:
1 or 2 tablets.
Narcotic blank required.

Potentiated Pain Relief

WINTHROP LABORATORIES
New York 18, N. Y. • Windsor, Ont.

Demerol (brand of meperidine),
trademark reg. U.S. Pat. Off.



DOCTORS NEED REMINDERS TOO

make a note to send for your **polio reminder cards** *today.*

Remember—every unvaccinated person under 40 should receive one of these reminder cards from his doctor.

Just fill in the coupon and mail it to

Public Relations Department
American Medical Association
535 N. Dearborn Street
Chicago 10, Illinois

please send me

_____ copies of the **A** Salk series reminder cards.
indicate quantity

_____ copies of the **B** Third shot reminder cards.
indicate quantity

NAME_____

ADDRESS_____

CITY_____ ZONE_____ STATE_____

HELP US KEEP THE THINGS WORTH KEEPING

All is calm, all is bright. In America we are free to worship as we please, where we please. And we worship in peace.

But like so many precious things, peace doesn't come easy. Peace costs money.

Money for strength to keep the peace. Money for science and education to help make peace lasting. And money saved by individuals.

Your Savings Bonds, as a direct investment in your country, make you a Partner in strengthening America's Peace Power.

The Bonds you buy will earn money for you. But the most important thing they earn is *peace*. They help us keep the things worth keeping.

Think it over. Are you buying as many Bonds as you *might*?

HELP STRENGTHEN AMERICA'S PEACE POWER

BUY U. S. SAVINGS BONDS

The U.S. Government does not pay for this advertising. The Treasury Department thanks, for their patriotic donation, The Advertising Council and this magazine.

ACHROCIDIN®

TETRACYCLINE-ANTIHISTAMINE-ANALGESIC COMPOUND LEDERLE

A versatile, well-balanced formula for treating common upper respiratory infections, particularly during respiratory epidemics; when bacterial complications are observed or are likely; when patient's history is positive for recurrent otitic, pulmonary, nephritic, or rheumatic involvement.

CHECKS SYMPTOMS: Includes traditional components for rapid relief of the traditional nonspecific nasopharyngitis, symptoms of malaise, chilly sensations, inconstant low-grade fever, headache, muscular pain, pharyngeal and nasal discharge.

Available on prescription only.

Adult dosage for ACHROCIDIN Tablets and new caffeine-free ACHROCIDIN Syrup is two tablets or teaspoonfuls of syrup three or four times daily. Dosage for children according to weight and age.

TABLETS *(sugar coated)*

Each Tablet contains:

ACHROMYCIN® Tetracycline	125 mg.
Phenacetin	120 mg.
Caffeine	30 mg.
Salicylamide	150 mg.
Chlorothen Citrate	25 mg.

Bottles of 24 and 100.

SYRUP *(lemon-lime flavored)*

Each teaspoonful (5 cc.) contains:

ACHROMYCIN® Tetracycline equivalent to tetracycline HCl	125 mg.
Phenacetin	120 mg.
Salicylamide	150 mg.
Ascorbic Acid (C)	25 mg.
Pyrilamine Maleate	15 mg.
Methylparaben	4 mg.
Propylparaben	1 mg.

Bottle of 4 oz.

Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

THE STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZED 1841

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Term Expires 1959

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Term Expires 1959

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Delegates to American Medical Association

(Terms end on December 31 of year indicated)

Stephen E. Gavin, Fond du Lac, 1958

D. H. Witte, Milwaukee, 1958
J. C. Griffith, Milwaukee, 1959

William D. Stovall, Madison, 1959

Alternates

L. O. Simenstad, Osceola, 1958

E. L. Bernhart, Milwaukee, 1958
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A. A. Quisling, Madison, 1959

The Wisconsin Medical Journal, Official Publication
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List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland–Bayfield–Iron	H. V. Sandin 220 Seventh W., Ashland	C. A. Grand 520 W. Second, Ashland	
Barron–Washburn–Sawyer–Burnett	C. J. Strang Barron	H. M. Templeton Barron	Second Tuesday 7:30 p.m.
Brown	George Nadeau 128 E. Walnut, Green Bay	Frank Urban 305 E. Walnut, Green Bay	Second Thursday*
Calumet	J. M. Guthrie 302 Cleveland, Brillion	J. W. Knauf Chilton	
Chippewa	B. J. Haines Cadott	R. L. Hendrickson 12 Third, Cornell	Second Tuesday
Clark	T. N. Thompson, Jr. Neillsville	H. M. Braswell, Jr. Owen	
Columbia–Marquette–Adams	H. A. Winkler 115 W. Chestnut, Pardeeville	T. S. Westcott Pardeeville	Every Third Month 7:00 p.m.
Crawford	O. E. Satter Prairie du Chien	H. L. Shapiro Prairie du Chien	Third Wednesday
Dane	L. E. Holmgren 30 S. Henry St., Madison	A. P. Schoenenberger 122 W. Washington, Madison	Second Tuesday Sept. through June
Dodge	R. F. Boock 119½ Front, Beaver Dam	G. G. Drescher 106½ Front, Beaver Dam	Last Thursday*
Door–Kewaunee	J. F. March 413 4th, Algoma	A. S. Lanier 3rd & Ellis, Kewaunee	
Douglas	R. T. Anderson 1507 Tower, Superior	L. R. Rosin 2231 E. Fifth, Superior	First Wednesday** Hotel Superior
Eau Claire–Dunn–Pepin	D. M. Willison 314 E. Grand, Eau Claire	K. E. Walter 131 S. Barstow, Eau Claire	Last Monday
Fond du Lac	John C. McCullough 20 Forest, Fond du Lac	R. W. Schroeder 330 Ledgeview, Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley Waheno	D. V. Moffet Crandon	
Grant	H. L. Doeringsfeld Platteville	H. W. Carey Lancaster	Last Thursday, March, June, Sept. and Nov.
Green	L. G. Kindschi 1770 13th, Monroe	J. A. Frantz Monroe Clinic, Monroe	

* Except June, July and August. ** Except July and August.

(Continued on next page)

List of Officers and Scheduled Meetings of County Medical Societies *(Continued)*

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Green Lake–Waushara	G. G. Mueller Princeton	J. C. Koch Berlin	Last Thursday, every other month starting in Jan.
Iowa	C. L. White Mineral Point	E. J. Hohler Mineral Point	First Thursday following first Monday
Jefferson	E. E. Burzynski 113 N. Third, Watertown	(Correspondence to President)	Third Thursday*
Juneau	J. H. Vedner Mauston	J. S. Hess Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	W. C. Kleinpell 723 58th, Kenosha	Mr. L. F. Jost, Ex. Sec. Box 669, Kenosha	First Thursday* Elks Club
La Crosse	F. J. Gallagher 630 S. Tenth, La Crosse	J. B. Durst 1707 Main, La Crosse	Third Monday
Lafayette	R. E. Hunter Argyle	N. A. McGreane 123 E. Ann, Darlington	Last Tuesday
Langlade	R. W. Cromer 824½ Fifth, Antigo	J. E. Garritty Antigo	First Monday
Lincoln	F. C. Lane 401 W. Main, Merrill	J. D. Millenbah 121 S. Mill, Merrill	
Manitowoc	J. W. Steckbauer Suite 304, Savings Bank Building, Manitowoc	D. A. Kuljis 1606 Washington Two Rivers	Last Thursday
Marathon	J. V. Flannery 808 Third, Wausau	R. B. Larsen 510½ Third, Wausau	
Marinette–Florence	Clarence H. Boren 1510 Main, Marinette	K. G. Pinegar 516 Houston, Marinette	Third Wednesday St. Joseph's Hospital
Milwaukee	S. A. Morton 3321 N. Maryland Milwaukee	L. R. Schweiger 324 E. Wisconsin Mr. J. O. Kelley, Ex. Sec. 756 N. Milwaukee, Milwaukee	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	H. A. Aageson 1113 Main, Oconto	C. E. Siefert Oconto Falls	
Oneida–Vilas	W. K. Simmons 1020 Kabel, Rhinelander	Marvin Wright 1020 Kabel, Rhinelander	Monthly
Outagamie	George A. Behnke 240 W. Wisconsin, Kaukauna	George A. French 601 W. College, Appleton	Third Thursday* Elks Club
Pierce–St. Croix	P. S. Haskins River Falls	P. H. Gutzler River Falls	Third Tuesday
Polk	Stella I. Burdette Balsam Lake	L. J. Weller Osceola	Third Thursday 7:00 p.m.
Portage	W. C. Sheehan 755 Strongs, Stevens Point	W. A. Gramowski 319½ Main, Stevens Point	
Price–Taylor	W. W. Meyer 410 S. Second, Medford	J. J. Leahy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
Racine	L. M. Lifschutz 816 16th, Racine	W. H. Williamson 1101 Grand, Racine	Third Thursday
Richland	George Parke 323 S. Central Richland Center	L. M. Pippin Richland Center	First Tuesday Richland Hospital
Rock	V. S. Falk 5 W. Rollin, Edgerton	E. S. Hartlaub 2020 Milwaukee, Janesville	Fourth Tuesday
Rusk	M. L. Whalen Bruce	H. F. Pagel Ladysmith	First Tuesday
Sauk	M. F. Huth 203 Fourth, Baraboo	J. J. Rouse Reedsburg	Second Tuesday*
Shawano	L. W. Peterson Shawano	A. J. Sebesta Shawano	Third Tuesday
Sheboygan	J. A. Russell Random Lake	R. M. Senty 1011 N. Eighth, Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	D. S. Sharp 140 E. Main, Mondovi	J. H. Noble 912 Harrison Black River Falls	Fourth Tuesday
Vernon	H. E. Oppert 318 S. Main, Viroqua	R. A. Starr Viroqua	Last Wednesday
Walworth	J. B. Schrock Sharon	W. C. Woods 607 Walworth, Delavan	Second Thursday*
Washington–Ozaukee	J. F. Walsh 125 E. Main, Port Washington	V. V. Quandt 57 S. Main, Hartford	Fourth Thursday
Waukesha	James V. Bolger, Jr. 102 E. Main, Waukesha	Philip Wilkinson 618 W. La Belle, Oconomowoc	First Wednesday
Waupaca	Owen Larson Clintonville	H. S. Caskey Clintonville	
Winnebago	P. S. Emrich 456 Mt. Vernon, Oshkosh	G. B. Hildebrand 59 Racine, Menasha	First Thursday
Wood	W. L. Nelson 480 E. Grand Wisconsin Rapids	J. R. Heersma 650 S. Central, Marshfield	Four times a year

* Except June, July and August.

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 15th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from individual members of the State Medical Society will be accepted without charge. The charge quoted previously applies to advertisements placed by clinics. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.

FOR SALE: Equipment of deceased physician, including a quartz light and standard x-ray machine, both about 28 years old; an examining table, splints, sterilizer. Contact Mrs. A. M. Rosenheimer, 125 Park Ave., Beaver Dam, Wis. 12–1*

FOR SALE: Physician's complete office equipment, large office, reasonable rent, good active general practice grossing 30 to 35 thousand. Step in and start working. Five thousand for equipment (large x-ray machine, lab., two diathermy machines, large safe, surgical instruments, two sterilizers, infra-red lamps, ultra violet, surgical spot lamps, cabinets, examination tables, office furniture, typewriter, adding machine, etc.) SPECIALIZING. Contact Box 757 in care of the Journal. m11tf

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WANTED: MEDICAL SPECIALIST for new building to open Jan. 1 at 1905 Monroe St., Madison. Rental space available on first floor, parking area, air conditioned and fire proof building. Contact William G. Healy, M.D., 1910 Monroe St., Madison, Wis. m11–12

YOUNG GENERAL PRACTITIONER wishes to associate with small group in Wisconsin. Had one year general practice prior to entry into Armed Service and is presently doing OB and GYN in the Army. Will be available in July 1959. Contact Box 760 in care of the Journal. p12

EENT PRACTICE for sale in southeastern city, with complete eye and ear equipment including Ritter eye and ENT units, audiometer, etc. 20 year records. Write Box 755 in care of the Journal. Will introduce. m11–12

DOCTORS' OFFICE SPACE AVAILABLE in beautiful new Brentwood Medical Arts Building, 2018 North Sherman Avenue, Madison. Private doctors' parking, public parking (40 cars), acoustical ceiling, mahogany paneling, heat and air conditioning, large reception room, black top parking area, pharmacy in building. On bus line, convenient to schools and churches. Address replies to Box 715 in care of the Journal. tfn

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FOR SALE: Monocular Zeiss microscope with two separate oculars and three objectives—low, high and oil immersion—with a rotating mechanical stage and a removable vernear mechanical stage. Cambridge electrocardiograph, portable "Simplitrol" model, not a direct writer. General Electric portable x-ray unit, model F with carrying case and accessories, 110 volts, 11 amps. All in good condition. Call Milwaukee—Humboldt 3–1218. m11–12

FOR SALE: 30 MA portable x-ray machine in good condition—will demonstrate. Price $250. Address replies to R. E. Hunter, M.D., Argyle, Wis. m11–12

UROLOGIST, board eligible, 30, desires association with an already established Board certified Urologist or group. Contact J. C. Beltran, M.D., 8527 Kathleen Ave., Affton 23, St. Louis, Mo. 10–1

PHYSICIAN NEEDED IMMEDIATELY: Thriving Wisconsin industrial and farming community of 1,200 with large surrounding area needs a physician immediately. New air conditioned clinic with large reception room, business office, 3 examining rooms and laboratory available for immediate occupancy. These facilities may be expanded as the need arises. Contact Box 752 in care of the Journal. 12tfn

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RESIDENT PHYSICIAN WANTED: For suburban hospital which was recently put in operation. Apply Administrator, Trinity Memorial Hospital, Cudahy, Wisconsin. Phone Hu. 1–3000. 12

FOR RENT: Four-room physician's suite, fully equipped, including a 100MA x-ray unit, in the business section of the city of Brookfield on the outskirts of Milwaukee. This suite is on the ground floor in a new air-conditioned clinic building. The area is very prosperous with rapidly expanding population and a doctor is badly needed. Very generous terms would be offered and long term financing is available. Address replies to Box 756 in care of the Journal. m11tf

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RETIRING! Anyone interested in the purchase of my 10-year-old office equipment, may do so with or without my 3-room office for $400, anytime between January and June, 1959. Karl Icks, M.D., 404 Northern Bldg., Green Bay, Wisconsin. m12—5

RADIOLOGIST: For Capitol Hospital, Milwaukee, Wisconsin. Contact: Administrator, Capitol Hospital, 1971 West Capitol Drive, Hilltop 2–9100, Milwaukee 6, Wisconsin. 8tfn

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RESIDENCY TRAINING AVAILABLE. Three-year Board-approved residency in Physical Medicine and Rehabilitation in 1300-bed Veterans Administration Hospital with Baylor University College of Medicine affiliation. Annual stipend: regular residency $3250–$4165; career residency $6505–$9890 (stipend dependent upon qualifications). Physicians qualified in specialty of PM&R are in great demand within the VA, private institutions of rehabilitation, private hospitals and private practice. Write Manager, VA Hospital, Houston, Texas. 10–12

FOR SALE: Excellent location for a younger man, looking for a completely equipped clinic office setup. This is a going practice and money maker from the start. Will introduce. Any terms agreeable. Reason—moving West. Write Box 758 in care of the Journal. p11–12

WANTED GENERAL PRACTITIONER: Two young established general practitioners desire association of a third in a small northwestern Wisconsin town. Large medical and surgical practice. Immediate partnership to the right man. Contact Box 345, Grantsburg, Wisconsin. 10–12

FOR RENT: Physicians suite available for immediate occupancy, ground floor, 11 rooms, large reception room, heated, good location, reasonable rent, 2609 University Ave., Madison, Wis. Phone Cedar 3–7105. Mrs. Ed Corcoran. p12–3

FOR SALE: Microtherm diathermy machine, three years old, used very little, like new, reasonable price. C. E. Siefert, M.D., 164 North Main Street, Oconto Falls, Wis., phone 9621. m11–12

THE PRACTICE OF A. F. RHEINECK, Suite 310, 2218 North Third Street, Milwaukee, Wisconsin, is immediately available to a qualified practitioner; equipment may also be purchased. All interested parties contact Attorney William E Glassner, Jr., 2218 North Third Street, Milwaukee, Wisconsin, FRanklin 4–0790. p8,tf

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WANTED: Psychiatrists or young doctors interested in psychiatry to work at Mendota State Hospital. These positions are permanent and under Civil Service, salary depends upon previous experience and training. Housing available on grounds. Contact Dr. W. J. Urben, Superintendent, Madison 4, Wisconsin. 8–12

WANTED: Internist to join three-man group of one surgeon and two general practitioners in northern Wisconsin city of 10,000. Excellent hospital facilities; salary open—early partnership. Write Box 759 in care of the Journal. p11–12

Exactly how does new Halodrin* restore the "premenopausal prime" in postmenopausal women?

Webster defines "prime" as the period of greatest health, strength, and beauty. In a woman, these are the childbearing years between puberty and menopause—the years when her hormone production is highest.

The inevitable reduction in this hormone production as she enters the menopause often results in physical discomfort in the form of hot flushes, nervousness, insomnia, or a multiplicity of other symptoms with which you are familiar. Superimposed on this physical picture is the psychic trauma brought on by this unavoidable evidence of aging. The thing that brings her to a physician is simply that she "feels bad."

You can't make her 35 again—but the odds are good that you can make her feel like it! The secret is a combination of reassurance and hormones. The exact form and amount of the former defy objective analysis, but the latter can now be provided with scientific precision. Reduced to essentials, here is the explanation of exactly how hormones—in the form of Upjohn's new Halodrin—restore the "premenopausal prime."

The normal premenopausal woman excretes estrogens in the urine in the form of estradiol, estrone, and estriol, in an approximate 28-day average ratio of 39:15:46. Starting with this urinary excretion of estrogens, it is possible to calculate backwards and estimate the amount of estradiol that must have been secreted endogenously in order to produce these urinary levels. This is possible because the proportion of estrogens which appears in the urine following parenteral administration has been established in castrated women.

On this basis, the average endogenous output of estrogens is about 160 micrograms per day during a menstrual cycle, and 80 micrograms per day in postmenopausal women (see chart opposite). Therefore, the restoration of the "premenopausal prime" in the postmenopausal woman requires the replacement of approximately the equivalent of the 80 micrograms of estradiol per day that she no longer secretes endogenously.

Oral ethinyl estradiol is about 2 to 2½ times as potent as parenteral estradiol. Therefore, the replacement of 80 micrograms of endogenous estradiol production per day is accomplished by the oral administration of 32 to 40 micrograms of ethinyl estradiol per day.

Each Halodrin tablet contains 20 micrograms of ethinyl estradiol, which means that the recommended dosage of 2 tablets per day provides 40 micrograms of ethinyl estradiol. This offsets the loss of 80 micrograms of endogenous estradiol production in the menopausal woman; i.e., restores the "premenopausal prime."

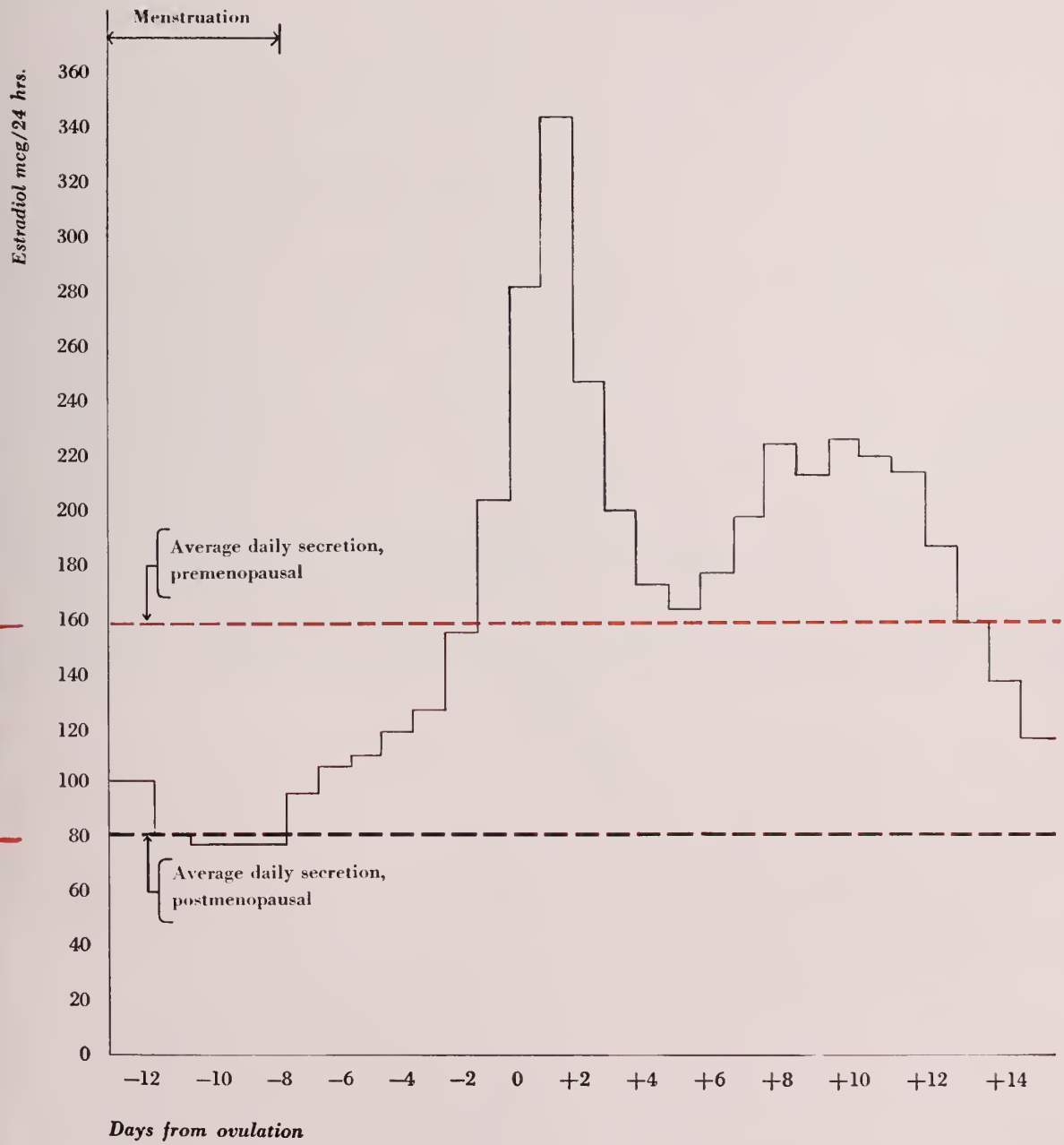
Each Halodrin tablet also contains 1 mg. of Upjohn-developed Halotestin* (fluoxymesterone)—the most potent oral androgen known. The primary purpose is to "buffer" the ethinyl estradiol just enough to prevent breakthrough bleeding, which is obviously undesirable in the menopause. It also exerts other beneficial hormonal effects, one of which, in common with ethinyl estradiol, is a powerful anabolic action so desirable in patients of advanced years.

Upjohn

*TRADEMARK, REG. U.S. PAT. OFF.

COPYRIGHT 1958, THE UPJOHN COMPANY

Endogenous estrogen secretion (mcg/24 hours) (calculated from average 24-hour urinary excretion of estradiol, estrone, and estriol)



*Compazine**

nausea and vomiting

—from virtually any cause

- in pregnancy—pre- and postoperative states—gastroenteritis—alcoholism—cancer and chronic diseases
- control is achieved with low dosage—usually 15 to 20 mg. daily—and often within a half hour after the first oral dose

'Compazine' is remarkable for its freedom from drowsiness. Patients carry on normal activities and often experience an actual alerting effect.

. . .for immediate control of severe vomiting:

Ampuls, 2 cc. (5 mg./cc.)

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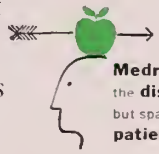

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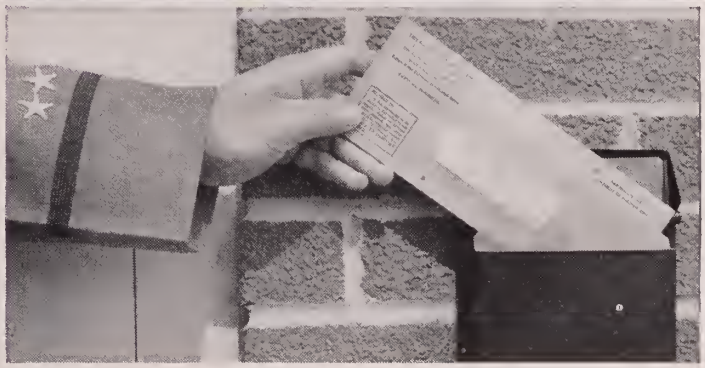

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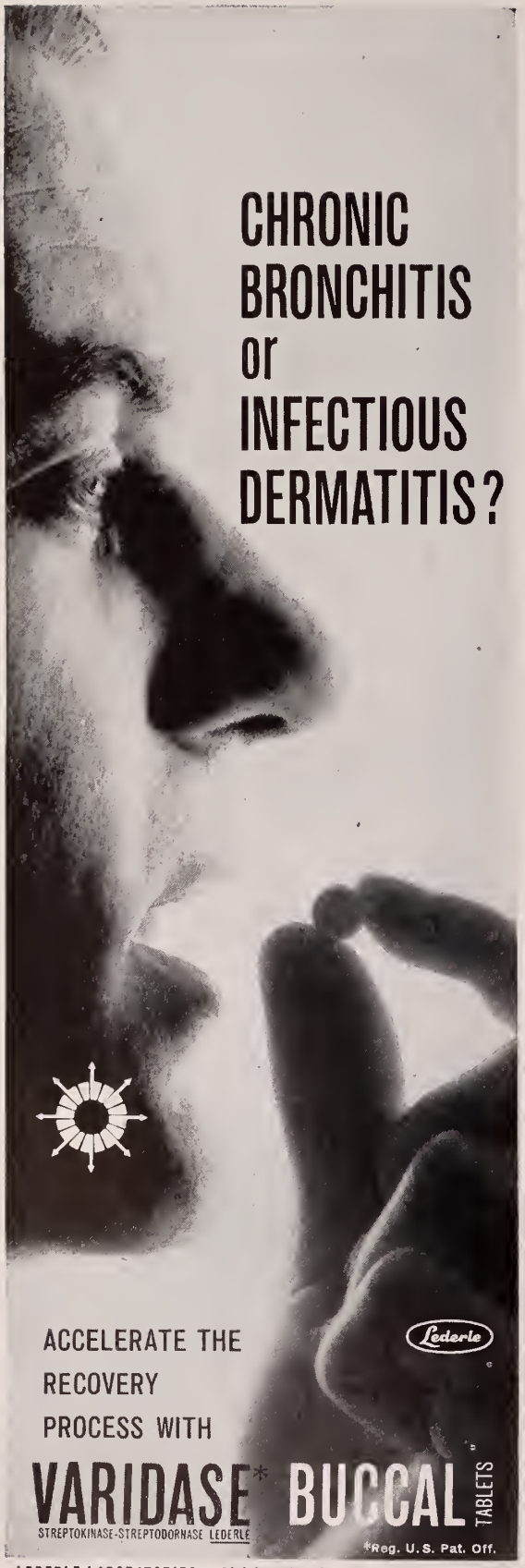

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Abdominal Pain in Children

By FRANK C. STILES, M. D.
Monroe

THE child whose chief complaint is abdominal pain, whatever its nature, presents a diagnostic challenge to the physician. Too often such children are given incomplete examinations and attempts made to allay the parents' worries by calling such pains "nervousness," colitis, fibromyositis, "flu," virus, functional, or a "touch" of this or that. The busy practitioner often finds it difficult to allot enough time to these children, because they do come in so frequently. In the pediatric department at the Monroe Clinic approximately six children per week come in because of abdominal pains.

Studies in large outpatient clinics have shown that 10% of all children entering complain of abdominal pain.[1]

How many of these children really have anything wrong? Aren't most of these functional? In our clinic we have been able to demonstrate definite pathology in about 15%. At the Children's Memorial Hospital, outpatient department, in Chicago, 95 children were investigated because of vague recurrent abdominal pain of two or more months' duration. These were white and colored children of 3 to 14 years who had complained of abdominal pain on two or more occasions. Some abnormality was demonstrated in 42%. In 20% the lesion shown was responsible for the abdominal pain.[1]

It is the purpose of this paper to present a practical method of evaluating the child with abdominal pain and then to consider some of the specific conditions which may cause abdominal pain.

Let us now consider some of these aspects in greater detail.

1. History and Physical Examination:

A return to the careful history-taking techniques learned in medical school is helpful. Where is the pain? Most younger children will point to the umbilicus regardless of the true location. Parents are helpful but often "too helpful" at first. If possible, it is preferable to ask the child himself first. Questions should then be asked of the parent concerning the duration, shifting location, sharp or dull nature, continuous or intermittent presence, and aggravating and relieving factors. General questions about the child's pain threshhold, appetite, weight loss, fever, and general health are also important. A

CHART 1—OUTLINE OF WORK-UP FOR ABDOMINAL PAIN IN CHILDREN

A. Basic Work-Up
1. Careful History and Physical Examination
2. Complete Blood Count and Urinalysis
3. Pinworm Smear

B. Further Evaluation
4. Flat Plate of Abdomen
5. Intravenous Pyelogram
6. Upper Gastrointestinal Series
7. Barium Enema
8. Gallbladder X-ray
9. Mantoux Test
10. Stool Examination
    - Blood (hematin or benzidine test)
    - Ova and Parasites
    - Culture for Pathogens
    - Smear for Eosinophils
11. Urine Test for Porphyrins
12. Other Tests
    - Heterophile Test
    - Sickling Test in Negroes
    - Liver Tests (cephalin flocculation, quantitative serum bilirubin, and quantitative urine urobilinogen)
    - Serology
    - Psychometric Examination
    - Electroencephalogram

(Modified from Wood, Hardy and White[1])

systemic review and past and family history should be taken if not well known.

Physical Examination: Good advice is given in the dictum, "Make haste by proceeding cautiously." It is essential to gain the child's confidence before proceeding with the examination even though this occasionally takes some time. Distraction by toys, books, or conversation can be a great ally. Very gentle superficial palpation of the abdomen should precede deep palpation. Sometimes an alternating pressure, first on one side of the abdomen and then on the other, seems to help the patient relax. Auscultation of peristaltic sounds should always be done.

A digital rectal examination, although often left until last, definitely should *not* be omitted.

Physical examination, of course, should not be limited to the abdomen. These children should receive a complete general physical check-up.

2. Complete Blood Count and Urinalysis:

This should always include a sedimentation rate. Abdominal pain is frequently found as one of the presenting symptoms of rheumatic fever. The sedimentation rate, although a nonspecific test, can be of great help in ruling in or ruling out disease. The presence of Paul–Bunnell cells in the differential blood count may suggest infectious mononucleosis. A leukopenia may suggest a viral infection. The hemoglobin, white blood cell count, or differential may all be very helpful.

Urinalysis is a "must." Even if the urinalysis is normal, an intravenous pyelogram should be done if no other cause for pain is found.

3. Pinworm Smear:

A Scotch-tape test for pinworm ova is easily done. Ideally this is performed in the morning; occassionally ova can be found on smears made in the afternoon. Although a direct cause and effect relationship between pinworms and abdominal pain does not always exist, there are still many cases where clearing up the pinworm infestation clears up the abdominal pain.

Further diagnostic work-up at this point should be at the discretion of the physician. If all studies have been normal up to this point, the physician may advise a further period of observation. On rare occasion a short time trial of some very mild sedative such as phenobarbital may be warranted. If, however, the physician feels that there is any possibility of the presence of an abnormality or if the symptoms of abdominal pain do not clear up, further studies are indicated. This might include the following:

4. Flat Plate of Abdomen:

A flat plate of the abdomen occasionally "saves the day." Although often normal, the x-ray film may reveal such things as unsuspected foreign bodies, certain bowel abnormalities, or tumors. The recognition of coproliths is very important in small children with abdominal symptoms since an immediate appendectomy is usually indicated. Recently in this area an ovarian teratoma in a 12-year-old girl was found after suspicious calcifications were seen on a routine film.

A chest x-ray is often advisable to rule out the presence of pneumonia.

5. Intravenous Pyelogram:

An intravenous pyelogram may reveal such abnormalities as ureteral obstruction, hydronephrosis, Wilm's tumor, polycystic or reduplicated kidneys, etc. A new technique which may be of value, especially in males, is the voiding urethrogram. It is very simple to do. At the conclusion of the pyelogram, the child is put in an oblique position and a film is taken while the child voids. This often shows abnormalities of the urethra better than retrograde studies. Cystoscopy and retrograde pyelography are of course indicated if complete information is not obtained from the urine and intranvenous pyelogram.

6. Gastrointestinal Series:

An upper gastrointestinal series may uncover an abnormality of the esophagus, stomach, or duodenum. The problem of peptic ulcer will be discussed separately. Diaphragmatic hernia or any number of abnormalities may be found. No work-up is really complete without a gastrointestinal series. In 1950 the author reported a rather unusual case of persistent epigastric abdominal pain in a 12-year-old girl.[2] X-ray studies revealed a large filling defect in the stomach thought to be due to extrinsic pressure by an enlarged spleen. At surgery a ball of hair or trichobezoar weighing 2½ pounds was removed from the stomach.

7. Barium Enema:

The lower gastrointestinal series or barium enema has its greatest usefulness in the diagnosis of malrotation of the bowel, intus-

susception, polyposis, bowel obstruction, or other abnormality.

8. Gallbladder X-Ray:

A gallbladder x-ray is something that is usually omitted in an examination of children. In children with unexplained abdominal pain or jaundice, cholelithiasis should not be forgotten in the differential diagnosis. Babbitt[3] recently published an interesting series of 4 cases of gallbladder disease in children.

9. Mantoux Test:

Intradermal testing for tuberculosis with a 1:10,000 or 1:1,000 dilution Mantoux test should be done. This method is preferable to the Vollmer patch test. Tuberculosis of the mesenteric lymph nodes can cause abdominal discomfort.

10. Stool Examination:

The test for blood in the stool should be done, preferably after a three-day, meat-free diet. In young infants, anal fissure is the most common cause of rectal bleeding. The axiom that high intestinal bleeding produces dark brown or old blood and low intestinal bleeding produces bright red blood can be used as a rough guide but is not invariably true. Bright red blood in the stool from a bleeding peptic ulcer has been observed. With Meckel's diverticulum, the blood may be either bright red or dark. Bleeding from a Meckel's diverticulum is often painless bleeding. Meckel's diverticulum may be referred to as the 2–2–2 condition: these diverticuli occur in 2% of children; their usual location is 2 feet from the ileocecal valve; and only 2% of them can be demonstrated by x-ray.

One of the most serious conditions causing bleeding is *intussusception*. The typical currant-jelly stool is usually a late finding, rarely 12 hours after onset but more often several days later. Intestinal polyps, amebic and bacillary dysentery, and intestinal parasites will also produce melena.

Stool smears may contain eosinophils in significant percentage. Allergic conditions and parasitic infestations must then be investigated.

11. Urine Test for Porphyrinuria:

The importance of testing the urine for porphyrin will be emphasized by a case report and discussion which follows.

12. Other Tests:

Abdominal pain in infectious mononucleosis is not uncommon. Eighty-four per cent of children with infectious mononucleosis have some liver involvement as evidenced by abnormal liver function tests.[4]

All negro patients should receive a test for sickling.

Studies for abnormalities of the liver may be helpful. Three tests commonly available which are of the most value include the cephalin flocculation test, quantitative van den Bergh's test, and quantitative urine urobilinogen. Liver function tests and other liver studies can then be done if indicated. Abdominal pain may occur in both clinical and subclinical cases of infectious hepatitis, for example. Blood serology for the problem case is important. Psychometric testing or help from a clinical psychologist or psychiatrist may be indicated in the more severe problems where organic cause has been ruled out and functional etiology is suspected. Electroencephalography testing is indicated for cases of suspected abdominal epilepsy.

In some patients even though a very complete work-up is done, no demonstrable cause of the abdominal pain is evident. Then the physician faces the problem of whether or not exploratory laparotomy is justified. There are no absolute rules to apply here and each case merits individual consideration. A period of observation often solves this problem. If after a patient has had a very thorough work-up and following a satisfactorily long period of observation there is no improvement in the patient's condition, surgical exploration is warranted. Trials of medication as a diagnostic aid are occasionally justified.

A few of the separate disease entities which may cause abdominal pain deserve special consideration.

Acute Appendicitis

Acute appendicitis cannot be handled in children as in adults. In children an accurate and early diagnosis is more difficult; peritonitis and rupture occur in a high percentage of cases; the untreated disease runs a more rapid and deadlier course.

Concerning the diagnosis of appendicitis, one or two points seem worthy of review. The classical triad of *abdominal pain, vomiting,* and *fever* in a child must be considered as diagnostic of appendicitis until proved otherwise. Vomiting and low grade fever are usually present. A loss of appetite is almost invariably found. Perhaps the most helpful

single criterion may be summed up in three words—persistent, localized, tenderness. The usual history is of acute abdominal pain followed by nausea and vomiting. This pain may be vague at the onset or may be around the umbilicus; but after a variable number of hours, this pain usually localizes in the right lower quadrant. An incompletely rotated colon may produce maximal pain in the right upper quadrant. Appendiceal pain, although usually constant, may be colicky because of obstruction of the appendiceal lumen by a concretion or by kinking.

Routine laboratory procedures should include a white blood cell count, differential, and urinalysis. There is usually, but not always, a leukocytosis with a "shift to the left" in the differential count. Total reliance cannot be placed on the hemogram. A recent 10-year-old patient of Dr. Edward Zupanc had the classical symptoms of acute appendicitis. The white blood cell count was 5,900 cells per cubic millimeter; 51% of these were small lymphocytes; 46% were segmented forms; only 2% were stab forms. Surgery was performed and a friable, gangrenous appendix was removed.

The importance of careful and repeated observations of suspected cases was illustrated by another recent patient.

> A six-year-old girl had pain in the right flank of six hours' duration. This radiated down to the bladder region. Fever and vomiting were also present. A catheterized urine specimen contained innumerable pus cells and many casts. The white blood cell count was 10,400 cells per cubic millimeter with a slight increase in immature forms. A diagnosis of urinary tract infection was made but the girl was carefully watched and rechecked a few hours later. Because of persistent tenderness in the right lower quadrant, surgery was decided upon even though it was felt that a normal appendix might be found. At surgery a gangrenous retrocecal appendix was found adjacent to the right ureter.

One very important diagnostic principle is illustrated here. If the diagnosis is not clear, very careful watching and rechecking is extremely important!

Dr. H. William Clatworthy, Jr., associate professor of pediatric surgery at Ohio State University, after reviewing the case histories of complicated appendicitis treated at the Columbus Children's Hospital, noted that the incidence of ruptured appendicitis during the World War II era was only 28% of the total cases admitted to this hospital with appendicitis. Since the war the incidence of ruptured appendicitis has never been below 35% and has recently ranged up to 40% of such cases. The problem of late diagnosis may be attributed to the fact that frequently children with abdominal pain, vomiting, and fever are not seen by the physician but are treated with antibiotics after a telephone consultation.[5]

If a calcified appendiceal concretion (coprolith) is found in a small child with abdominal symptoms, immediate surgery is necessary since there is a 90% chance the patient has acute appendicitis and a 48% chance that the appendix is gangrenous or perforated.[6] In symptom-free older children having coproliths, surgery is usually not indicated.

The problem of the child with the so-called chronic appendix is common. These children have repeated bouts of right lower quadrant pain with or without fever and vomiting. The physician frequently receives much pressure from worried parents: "I know something is wrong. We want something done." Interval appendectomies on these children have produced appendices in which there is demonstrable pathology in less than 50% of most published series. The decision as to whether to operate on these patients must be made on an individual basis.

Children who have recurrent attacks of acute mesenteric adenitis also may become free of abdominal pain after appendectomy. The mechanism of this is obscure and the incidence of improvement insufficient to warrant surgery in other than the very occasional case.

Peptic Ulcer

Peptic ulcer, either of the stomach or duodenum, is not a common condition. Some radiologists are too prone to diagnose this condition simply if they find evidence of spasm. One should be reluctant to accept a diagnosis of peptic ulcer in a child unless a definite ulcer crater can be demonstrated. Gross[7] states that in 6,059 autopsies at the Glascow Royal Hospital for Sick Children, Guthrie found only 9 cases of peptic ulcer. Some 350 or more cases of peptic ulcer in children have been reported in the literature. On the other side of the picture, though, one point needs emphasis. In most reported cases, the ulcer is discovered only at autospy which, as Doctor Gross states, "would suggest that there is room for improvement in recognizing the condition in life."[7]

During the first two years of life, peptic ulcers usually cause no demonstrable symptoms. After this age the condition is similar to that found in adults. Several cases of perforating peptic ulcer have been reported in very young infants and prematures. If free air is seen under the diaphragm in an upright film of the abdomen in the child, perforated peptic ulcer may well be the abnormality.

In young children with proved peptic ulcer, the results of both medical and surgical treatment is poor. The mortality rate for cases under two years of age treated by surgery is about 70%.[7] Medical treatment is not much better. Comparable mortality rates are inaccurate because it is the more serious cases that usually receive surgery. In children over two years of age, the mortality following surgery is less than 5%.[7]

Abdominal Epilepsy

Abdominal epilepsy has been an abused term in some places. There are a number of very competent observers who doubt that such an entity exists. As Peterman[8] points out, abdominal pain is one of the most frequent childhood complaints and relief of abdominal pain by phenobarbital or diphenylhydantoin does not prove a diagnosis of abdominal epilepsy. Apley, *et al.*,[9] feel that the supposed relationship between abdominal pains and cerebral dysrhythmia often may have been based on a failure to compare electroencephalograms of children having the manifestations with electroencephalograms of apparently normal children. It is evident, therefore, that at present abdominal epilepsy is a controversial diagnosis.

A very few cases seem to fulfill the diagnostic criteria of abdominal epilepsy.[10, 11, 12] One such patient has been seen in this clinic. The criteria for diagnosis are as follows:

1. There should be a history of sudden paroxysmal abdominal pain, usually periumbilical or epigastric; frequently followed by exhaustion and sleep.
2. There should be exclusion of intrinsic visceral disease by an adequate examination and laboratory investigation.
3. An abnormal electroencephalogram showing psychomotor disturbance.
4. *Clinical and electroencephalographic response* to anticonvulsant drugs.

These patients do poorly on ergotamine and barbiturates. Livingston, in 14 cases, reported good results using diphenylhydantoin.[13]

Porphyria

Our attention at this clinic has become focused on *porphyria* as a possible cause of abdominal pain. Porphyria is a constitutional defect in the metabolism of pyrroles. The history of a 12-year-old patient is illustrative of the usual pitfalls encountered by these children before a diagnosis is made.

This 12-year-old girl was first seen at the age of 10 years and had complained of abdominal pain for four years previously. Attacks came at varying intervals, usually six weeks apart. The location was not constant. Often it was in the area of the umbilicus. The pain often shifted to different parts of the abdomen. Alka-seltzer seemed to relieve the pain for short periods of time. The mother noticed that the girl was often nervous or upset prior to an attack. No foods were known to precipitate the attacks. The attacks lasted from a few minutes to several hours. The girl had been seen by a number of physicians.

A barium study of the upper and lower gastrointestinal tract and a cystoscopic examination in a hospital had been reported as negative. This mother was told the trouble was "nerves." Two days prior to being seen at this clinic, the child had a severe attack lasting for a number of hours. She also had a high fever and was reportedly delirious. No other significant factors were elicited at this time in the history. The child's mother had had many types of surgery and was also "nervous."

Physical examination revealed no abnormality. The child's temperature was normal. A complete blood count, urinalysis, and sedimentation rate were normal. It was felt that the child's abdominal complaints were probably functional. An antispasmodic was prescribed.

Several months later the child again had abdominal pain. Pinworm ova were found. This infestation was cleared up, but the child's symptoms persisted. During the next year the child was seen by three different physicians. Diagnoses of kidney infection and abdominal flu were made. The child then returned. Previous studies were repeated. In addition, upper and lower gastrointestinal series and intravenous pyelogram studies were done and were negative. A functional disease diagnosis was again made and a tranquilizer and magnesium and aluminium hydroxides (Maalox) prescribed. The mother was then given a thorough "sales talk" on psychosomatic illness.

After several months during which the child was free of pain, the attacks resumed and the child was admitted to the hospital for exploratory laparotomy.

A previously overlooked or underemphasized fact was then noted. Prior to an attack, the girl exhibited marked behavior changes. The girl became depressed, irritable, antagonistic, and totally unmanageable.

As a part of the preoperative work-up, urines were tested for the presence of coproporphyrins and uroporphyrins. Positive tests were found on repeated testing on successive days. Surgery was cancelled.

Abdominal pain in this case was in all probability due to acute intermittent porphyria. There are some valuable lessons learned from this case. If this child's case had been more thoroughly worked-up from the beginning, a great deal of needless expense later could have been avoided.

Acute intermittent porphyria is something that should be ruled out on any child with intermittent vague abdominal pain. As Markovitz[14] emphasizes, the classic triad of symptoms of abdominal pain, peripheral neuropathy, and mental or psychic changes is not always seen. Some patients are totally asymptomatic. Not all these patients excrete the well-known Burgundy-red urine. In others the urine may be normal color or the presence of abnormal porphyrins in the urine is only an occasional occurrence, necessitating repeated examinations before a diagnosis can be made. Some patients have no porphyrinuria during an acute attack but these substances appear during recovery.

Fever is present in 30% and leukocytosis is present in about 50% of these patients.[14] This often gives the surgeon the needed impetus to do a laparotomy. Most children having this disease undergo one or more abdominal explorations before a correct diagnosis is made.

Mental or psychic changes are nearly always seen and cranial or peripheral nerve involvement is common. A family history of the disease is found in less than 50%.[14] There is no specific therapy. The mortality rate is high (58%)[14] and therefore the prognosis must be very guarded.

In abdominal pain, then, with minimal physical findings, the diagnosis of porphyria should not be overlooked.

Acute Pancreatitis, Hereditary Pancreatitis

Pancreatitis, as seen in adults with accompanying severe abdominal pain, is rarely seen in children. Occasionally childhood mumps may be complicated by pancreatitis. In such cases, there is usually an abrupt onset of severe constant abdominal pain, often localized in the area of the umbilicus or in the epigastrium; shock, nausea and vomiting are almost always present.[15]

The recently described clinical entity of hereditary pancreatitis in children deserves emphasis. This disease which may be related to porphyria has been described in detail by Gross, Comfort and Ulrich.[16] These authors have carefully observed several families where a number of the members have shown manifestations of this disease. To quote these men, "Hereditary pancreatitis is characterized by . . . severe prolonged seizures of pain in the upper abdomen and back, and in the course of time the resultant pancreatic destruction may be followed by any or all of the same sequelae: diabetes mellitus, pancreatic calcifications, ... etc." These authors have demonstrated an excessive urinary excretion of the amino acid, lysine, in patients with hereditary pancreatitis. Positive urine tests for porphyrins have been observed in some of these patients. The significance of these is not known.

Functional Abdominal Pain

Finally, we must consider the child whose pain is truly functional. Although this topic is considered last, it is not the least in importance. In the younger age group, many children find they have a wonderful weapon to use against their apprehensive "mommie." Just by saying, "My tummy hurts," they can avoid eating things or can get additional attention. When such children are brought to the doctor, it is often the mother, not the child, that needs the treatment. Disregarding such statements that they have a tummy ache may eliminate the complaint. In many of these cases, it is advisable or necessary to do a complete work-up before positive reassurance can be given the worried mother.

At about 7 years of age abdominal pain in children is so common that it is sometimes called the "7-year-old disease." The incidence is slightly higher in boys. In most of these the pain is so vague as to location, duration, and intensity that the examiner almost at once doubts the presence of any real disease. After a careful history and physical, usually including a blood count, urinalysis, pinworm smear, and occasionally a flat plate of the abdomen, the author tries to reassure the mother that, to the best of his knowledge, no serious disease is present and that she should try ignoring the symptoms. If the child con-

tinues to complain, a complete work-up is then advised.

Another frequently encountered problem is that of the boy or girl in his early teens who gets a sharp "side ache," often after exercising. This is usually a very real pain, and the etiology is obscure. Some of these patients have come to surgery; it is most common to find nothing. A number of theories have been advocated to explain these pains. Accelerated growth in early adolescence causing a slightly different position of abdominal viscera could conceivably play a role. An abnormal pull on a mesentery has been ascribed by some. Actually no one knows. These youngsters outgrow this discomfort. In some cases restriction of activity is necessary.

It is not within the scope of this paper to list all the multitude of possible causes for abdominal pain in children. Congenital anomalies and anatomical abnormalities must, of course, not be forgotten. In addition to standard textbooks of differential diagnosis, a number of excellent treatises on abdominal pain in children have been published.[1, 7]

Summary

A practical approach to the diagnosis of abdominal pain in children has been presented. Acute appendicitis, peptic ulcer, abdominal epilepsy, porphyria, hereditary pancreatitis, and functional abdominal pain have been given separate, more detailed consideration.

The Monroe Clinic.

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NORTH SHORE HOSPITAL LECTURE WEDNESDAY, JANUARY 7

The fourth lecture in the Ninth Annual North Shore Hospital lecture series on "Emotional Forces in the Family" will be held at the hospital, 225 Sheridan Road, in Winnetka, Illinois, on Wednesday, January 7, 1959, at 8:00 P.M. "The Role of Children in the Family" will be discussed by Sidney Berman, M.D.

Doctor Berman is a member of the faculty, Washington Psychoanalytic Institute; assistant clinical professor of psychiatry, George Washington School of Medicine; attending staff, pediatric psychiatry, Children's Hospital, Washington, D. C.; consultant, Laboratory of Child Research, National Institute of Mental Health.

The Commission on Education of the American Academy of General Practice has approved these lectures for Category II credit. Doctor Berman will answer questions after his presentation. All physicians and allied professional personnel are welcome to attend.

NEW BOOKLET ON CARDIOVASCULAR DISEASE STATISTICS

A booklet that answers some of the more common questions asked about cardiovascular disease statistics has been published by the American Heart Association in cooperation with the National Heart Institute and the Heart Disease Control Program of the Public Health Service.

The booklet, entitled, "Cardiovascular Diseases in the U.S.—Facts and Figures," is available from the Wisconsin Heart Association, 441 West North Avenue, Milwaukee 12.

The booklet concerns itself only with mortality figures available from the National Office of Vital Statistics, the Bureau of Census and the World Health Organization. No morbidity data are presented because, the booklet points out, there are no recent reliable estimates of incidence or prevalence of cardiovascular diseases on a nationwide basis.

Illustrated with charts and graphs, the 12-page booklet should be of use to physicians and other professional persons in the heart fields.

PREPARATION OF MANUSCRIPTS FOR THE WISCONSIN MEDICAL JOURNAL

Exclusive Publication: Articles are accepted for publication on condition that they are contributed solely to this Journal. Publication elsewhere will be subsequently authorized in the discretion of the Medical Editor.

Correspondence: Address all correspondence relating to publication of scientific papers to the Medical Editor, Box 1109, Madison 1, Wisconsin.

Manuscript: Type double spaced, on 20 pound white paper, 8½ by 11 with one inch margins at the top, bottom, and right, and 1½ inches on the left. Submit the original and two carbon copies. Use the metric system throughout. Call drugs by their generic names. The trade names can be added, in parenthesis, if they are considered important. Keep one copy of the paper.

Identification: Place the name of author and page number at the upper left-hand corner of each page except the first.

Footnotes and References: Use the style of the *Quarterly Cumulative Index Medicus* published by the American Medical Association, which requires, in the order given: name of author, title of article, name of periodical, with volume, pages, month—day of month if weekly—and year as follows:

4. Doe, J. E.: What I know about it,
Wis. Med. J. 54:717–719 (Dec.) 1954.

And, include only those references specifically referred to in the text.

Reprints: An order slip for reprints with a table covering cost will be sent with the page proof to each contributor.

Illustrations: Four illustrations per article are allowed without cost to the author. Beyond this number the author must pay the actual cost of illustrations. Place the name of the author on the back of each illustration, table, etc. Submit clear and distinct 3 by 5 glossy photographs. Make drawings in black ink on white paper. Attach a slip of paper to the bottom of the illustration with the author's name, identification of article, and appropriate legend. Photographs and drawings will be returned if so requested.

Under ordinary circumstances articles are scheduled about six months in advance. The approximate date of publication, subject to change, will be given the contributor when the article has been accepted.

Society members throughout the state are encouraged to write up their interesting cases and submit them for publication. The editorial staff welcomes the opportunity of helping you prepare your article for the printer.

Cardiac Arrest: A Case Report and Discussion

From the Wisconsin Anesthesia Study Commission of the
Wisconsin Society of Anesthesiologists

By T. C. SMITH, M. D., KARL L. SIEBECKER, M. D., and O. S. ORTH, M. D.*
Madison

IRREVERSED cardiac arrest occurred in the following case. It is presented for consideration because of the pharmacological agents employed both by the anesthesiologists and the surgeon, the operative position of the patient, and dependence on monitoring equipment for vital physiological information.

Case Summary

A 67-year-old white retired janitor was admitted to the hospital with the chief complaint of slowly increasing dizziness of about six weeks duration. The "dizziness" was not true vertigo, but rather weakness and "lightheadedness."

The patient had been in good health prior to the onset of the dizziness. An appendectomy had been performed under general anesthesia 17 years prior with uneventful recovery. The patient's wife stated that he had been coughing every morning for 10 weeks prior to admission. Associated complaints offered by the patient included paresthesia of the right side of the face and right extremities, sudden postprandial forceful emesis, and a 25-pound weight loss.

Physical examination revealed an alert, elderly, weak, white male with a blood pressure of 150/90. Except for neurological examination there were no remarkable signs. Left lateral nystagmus, a positive Romberg test (left), diplopia with far left lateral gaze, ataxia on the left finger-nose test, mild left hemiparesis, and questionable facial asymmetry were found. The clinical impression on admission was a space-occupying lesion of the brain.

The usual urine, hematologic, and chemistry studies were not remarkable. A chest film, upper and lower gastrointestinal series, proctoscopy, and routine and Stenver views of the skull were not remarkable. Neurology and neurosurgery consultants agreed that brain tumor was the tentative diagnosis.

Pneumoencephalography on two occasions failed to demonstrate the fourth ventricle, as did ventriculography. The patient became progressively more nauseated, requiring intravenous support. A small pneumoencephalogram (Robertson's procedure) was performed four weeks after admission, with undiagnostic findings. Immediately following this examination suboccipital craniotomy was elected.

Premedication for the pneumoencephalogram had been 60 mg. of codeine sulfate, given subcutaneously at 7:30 A.M. When the patient arrived in the operating room his physical status was judged to be 3. Two-tenths of a milligram each of l-hyoscyamine and hyoscine were given intravenously at 9:15. The blood pressure was recorded as 110/70. The hypopharynx was then sprayed with 4 cc. of 5% hexylcaine. Four hundred milligrams of 2½% thiopental was given intravenously over a four-minute period. At 9:20 A.M., 60 mg. of succinylcholine was given intravenously. The patient was then ventilated with oxygen for 60 seconds. A No. 37 French anode tube with cuff was placed in the trachea. Oxygen was again given until spontaneous respirations returned. Nitrous oxide and oxygen in 3:1 ratio was then administered using a Stephen–Slater non-rebreathing valve. At 9:30 A.M., chloroform supplementation was added using a vinyl ether vaporizer.

The patient's lower extremities were wrapped in Ace bandages. A No. 15 needle was placed in a left hand vein and 5% dextrose in water was given by slow intravenous drip. Over a 25-minute period the patient was raised from supine to sitting position with cervical hyperflexion maintained by a suboccipital headrest. The patient coughed several times during this procedure. *Urea solution (30% in invert sugar) was given intravenously to decrease cerebrospinal fluid and brain volume*, starting at 9:55 A.M. The blood pressure increased to 130/110 coincident with this; respiration and pulse rate increased from 20 and 90 respectively to 30 and

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120. These vital signs returned to preoperative levels over the next 45 minutes, during which time the patient's head was shaved, prepared, and draped. An electrocardiac pulse monitor was applied with needle electrodes.

Just prior to the surgical incision the blood pressure was 110/85, pulse 80, respirations 20, and minute volume 4 liters. As the incision was made the patient coughed and the minute volume rose to 8 liters per minute. A tracheobronchial toilet was done but little material was obtained. The endotracheal tube was withdrawn one inch. The patient coughed again. The patient was estimated to be in the first plane of surgical anesthesia at 10:45 A. M. The blood was bright red in the incision. Nitrous oxide was discontinued shortly and the patient maintained on oxygen and small amounts of chloroform.

As the deeper muscle layers were being divided the blood was noted to be darker in color. Respirations were assisted. At 10:55 A. M. the pulse was palpable and the heart monitor was "beeping" regularly. At 10:57 A. M. the pulse could not be palpated. However, respirations were continuing unchanged, spontaneous, and adequate; and the monitor indicated a continuing regular electrical activity of the heart. As a precaution the chloroform was discontinued, and 100% oxygen administered. Several minutes were spent trying to palpate a pulse, to auscultate heart sounds under the drapes, and attempting to measure blood pressure by both auscultation and palpation. During this time the monitor continued demonstrating regular electrical activity of the heart, and respirations were rhythmical and adequate. At this point 11.5 cc. of chloroform had been volatilized over an 87-minute period in a 10-liter-per-minute flow of diluent gas, largely 75% nitrous oxide and 25% oxygen. From the molecular weight and specific gravity this calculates to an *average chloroform concentration of 0.37%*.

The diagnosis of cardiac arrest was made at 11:01 A.M. when no precordial heart sounds could be heard. The patient was then undraped and placed supine. The cumbersome headrest caused further delay. Thoracotomy was performed and cardiac massage begun at 11:05. This represents a *delay of eight or nine minutes* from time of onset of the arrest. At this time the heart was observed to be in asystole, flabby, cyanotic, and dilated. *The cardiac monitor was still indicating regular rhythmical electrical activity*, and spontaneous respiration continued.

Massage was continued by a senior resident in thoracic surgery. A surgically exposed vein was used to administer blood when the previously placed needle became dislodged. Epinephrine and phenylephrine were given by intracardiac injection on three occasions. The resulting heart beat was weak. Massage produced a systolic blood pressure of 60 to 70 mm. of mercury. Electrocardiographic tracings revealed an idioventricular pattern. Levarterenol was given by intravenous drip and later procaine amide was given in increments to a dose of 1 gm. Adequate cardiac activity never returned. From 11:45 A.M. until 12:20 P.M., respiratory activity became first slow and deeper, then slower and weaker. At 12:21 P.M. ventricular fibrillation was observed grossly, and by electrocardiographic tracing. Further efforts at resuscitation were discontinued.

At the time of thoracotomy an indurated tumor was palpated behind the heart in the hilar structures. Frozen section of a node from this area revealed adenocarcinoma. Permission for an autopsy was obtained from the relatives. The autopsy revealed:

Bronchiogenic adenocarcinoma, partially obstructing the left main bronchus, with metastases to right lung, kidney, cerebellum, cerebrum, brain stem, regional nodes, and left adrenal.
Atelectasis, marked, left lower lobe.
Empysema, moderate.
Hydrocephalus, secondary.
Pressure cone of brain stem, marked.
Pressure cone of cerebellum, marked.
Edema, collateral, left cerebellum.

Discussion

This case report merits consideration on the basis of at least four factors: (1) the use of chloroform as a supplement to nitrous oxide for anesthetization, (2) the use of urea intravenously to reduce intracranial pressure, (3) the operative position of the patient, and, particularly, (4) the use and dependability of cardiac monitoring devices.

Individuals acquainted only theoretically with chloroform, chiefly from pharmacology textbook descriptions of its supposedly greater hepatic, renal, or cardiac toxic actions, tend almost routinely to deplore its usage. To those who have actually employed chloroform and who are aware of its indica-

tions and limitations an entirely different attitude exists. They realize that with adequate oxygenation and full ventilation for carbon dioxide removal this agent has approximately the same hepatic, renal, and cardiac effects as the other fully potent general anesthetic agents.[1] A nitrous oxide-oxygen mixture which has been inadequate anesthetically usually will be converted to a potent anesthetic mixture with the addition of less than 0.5% of chloroform in the inspired atmosphere. Oxygen can be maintained at or above the 20% atmospheric concentration which has been sufficient in the pre-anesthetic state. For the particular case here presented oxygen was at a 25% concentration or above at all times. Respirations were assisted to augment carbon dioxide removal via greater tidal exchange and increased minute volume.

Chloroform in adequate concentration most certainly can produce cardiac arrest. With constant attention to the pulse and blood pressure there is ample warning of overdosage, from slowing of the heart and decline of pressure, to prevent such an accident. It is not believed there was any such cause for this patient in view of the close observance of such signs and the minimal concentration of chloroform which was used.

Urea is being administered intravenously with increasing frequency as an extremely effective agent for the reduction of intracranial pressure.[2] The reduction in volume of the brain and thereby better exposure obtained may permit the neurosurgeon to accomplish a hitherto impossible task. The mechanism of pharmacological action of urea has not been fully determined. It does not appear to be entirely via renal function since there is reduced intracranial pressure in bilaterally nephrectomized animals. Whether the alteration in volume of the brain and spinal cord in this patient could have permitted downward displacement of higher structures containing vital centers is debatable. It must, however, be considered a distinct possibility.

The sitting position of the patient, too, could have caused the physical phenomenon of a pressure cone in the medullary and cerebellar areas with altered function of vital centers. Even the extreme flexion produced for such operations has been reported to cause such phenomena in patients where there was pre-existing elevated intracranial pressure such as this patient possessed. Such an occurrence could well explain the cardiac arrest which arose. Delay in lowering patients from cumbersome headrests always is feared if the necessity arises in neurosurgical procedures. The requirement for such positions for successful anatomical exposure is evident, but there exists the need to be able to return patients quickly to more physiologically tolerated axes. Improvement in manufacture of operating equipment to permit such return is to be greatly encouraged.

There is an increasing tendency in all phases of medicine toward instrumentation, to rely on more "gadgets" and machines. All such equipment has marked usefulness but there also are definite limitations and frequently serious drawbacks. It is well recognized for instance that the electrocardiograph records *only* electrical activity of the heart. Thus, electrocardiograms of almost a normal character may be obtained for a considerable length of time after mechanical function (cardiac output) has ceased. As is demonstrated in the case presented herewith, the cardiac monitor continued to function well beyond the time the heart had failed in necessary action. Thus, valuable time was lost in initiating corrective procedures. Nothing can exceed in value the palpating finger for assessing the functional status of the cardiovascular system. Knowledge of the rate, rhythm, and quality of the pulse are almost invaluable, in fact may be lifesaving, in what is learned in comparison to expensive and often capricious instruments.

More and more operating room teams have come to realize that the early seconds (not long minutes) are the vulnerable period for successful cardiac resuscitation. Unless function is restored, at least for cerebral blood flow, within three or four minutes, irreparable cortical damage usually is seen. A well-devised plan of action and coordinated effort by all the team members is necessary for successful survival of the patient. In this particular instance a time lag between the cardiac arrest and the diagnosis plus the difficulty in placing the patient in an accessible position made impossible any chance of reversal of the cardiac arrest.

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ANNUAL CLINICAL CONFERENCE, CHICAGO MEDICAL SOCIETY

The Chicago Medical Society Annual Clinical Conference will be held March 2, 3, 4 and 5, 1959 at the Palmer House in Chicago. Daily half-hour lectures by outstanding teachers and speakers on subjects of interest to both general practitioner and specialist have been arranged. There will be panels on timely topics, teaching demonstrations, medical color telecasts, instructional courses, and scientific exhibits.

SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

"March of Medicine" is in its thirteenth consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin, discussing various health problems with a lay person who is called "Your Medical Reporter." At present 41 stations in Wisconsin are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Day*	*Time*
WATK	Antigo	Saturday	8:45 a.m.
WATW	Ashland	Saturday	4:45 p.m.
WGEZ	Beloit	Saturday	10:45 a.m.
WWIS	Black River Falls	Saturday	9:10 a.m.
WAXX	Chippewa Falls	Saturday	12:45 p.m.
WBIZ	Eau Claire	Sunday	7:00 p.m.
WEAU	Eau Claire	Saturday	11:45 a.m.
KFIZ	Fond du Lac	Thursday	7:15 p.m.
WBAY	Green Bay	Saturday	5:15 p.m.
WTKM	Hartford	Tuesday	11:00 a.m.
WHSM	Hayward	Saturday	8:05 a.m.
WCLO	Janesville	Tuesday	8:15 p.m.
WLIP	Kenosha	Saturday	9:05 a.m.
WKBH	LaCrosse	Saturday	10:45 a.m.
WLDY	Ladysmith	Saturday	9:00 a.m.
WHA	Madison	Friday	10:30 a.m.
WIBA	Madison	Saturday	11:15 a.m.
WOMT	Manitowoc	Saturday	9:15 a.m.
WDLB	Marshfield	Saturday	9:45 a.m.
WIGM	Medford	Saturday	10:00 a.m.
WEKZ	Monroe	Saturday	1:45 p.m.
WCCN	Neillsville	Saturday	9:30 a.m.
WPFP	Park Falls	Saturday	10:45 a.m.
WSWW	Platteville	Saturday	9:05 a.m.
WPDR	Portage	Thursday	10:15 a.m.
WIBU	Poynette	Thursday	2:30 p.m.
WPRE	Prairie du Chien	Saturday	10:15 a.m.
WRJN	Racine	Sunday	6:30 p.m.
WRDB	Reedsburg	Saturday	12:45 p.m.
WOBT	Rhinelander	Saturday	10:15 a.m.
WJMC	Rice Lake	Saturday	9:45 a.m.
WRCO	Richland Center	Saturday	5:15 p.m.
WCWC	Ripon	Saturday	9:15 a.m.
WTCH	Shawano	Sunday	6:45 p.m.
WSHE	Sheboygan	Friday	2:45 p.m.
WDOR	Sturgeon Bay	Thursday	10:45 a.m.
WTRW	Two Rivers	Saturday	11:15 a.m.
WTTN	Watertown	Tuesday	11:30 a.m.
WRIG	Wausau	Sunday	11:00 a.m.
WSAU	Wausau	Saturday	5:15 p.m.
WBKV	West Bend	Saturday	11:15 a.m.

Diagnosis of Coarctation of the Aorta

By RICHARD J. BOTHAM, M. D., WILLIAM P. YOUNG, M. D., and JOSEPH W. GALE, M. D.*
Madison

IT HAS frequently been said that palpation of peripheral pulses and a high index of suspicion is all that is necessary to lead to a diagnosis of coarctation of the aorta. Diminished femoral pulsations are readily discernible in a quiet infant and therefore one would conclude that the initial diagnosis of coarctation of the aorta should nearly always be made in infancy or childhood during routine examination by the family physician. Although the diagnosis is often made in infancy or childhood, all too frequently it is only later that evidence of hypertension, or heart failure, a cerebral vascular accident, or an abnormal routine chest x-ray herald the presence of the previously undiagnosed coarctation. Not uncommonly the physician ultimately diagnosing this condition, while experiencing a sense of satisfaction, reflects about the reason why previous examinations by his medical colleagues have not disclosed the presence of the underlying lesion.

Palpation of the femoral pulse in an active, crying infant at the time of an initial physical examination following birth can be anything but satisfactory, and it is not surprising that absent or diminished femoral arterial pulsation goes undetected at that time. The growth and development of a patient with coarctation is usually normal and unless early heart failure intervenes or there are other associated cardiovascular anomalies that call attention to the vascular system, the ultimate diagnosis often awaits the development of more obvious findings.

A review of the diagnostic findings in a series of cases of coarctation of the aorta has impressed us with the fact that not infrequently more than simple palpation and a high index of suspicion is necessary to lead to a diagnosis of coarctation. Equally important is the fact that corroborative tests have often revealed the presence of other significant congenital cardiovascular defects, many of which, although formerly not correctable, are now amenable to surgical therapy.

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It behooves the physician to be aware of the significance of the usual as well as the unusual diagnostic findings in a case of coarctation. The presence of unusual findings may be an indication for more extensive investigative procedures as well as expert guidance in determining the ultimate therapeutic approach or procedure. We feel that a presentation of the importance of the diagnostic findings in a series of proven cases of coarctation is worthwhile at this time.

Material and Methods

Fifty-nine cases seen at the University of Wisconsin Hospitals in the 11-year period, 1947–1957, in which a diagnosis of coarctation of the aorta was confirmed at surgery, form the basis of this presentation. The histories, physical findings, operative pathology, electrocardiography, and roentgenology reports have been reviewed. The expected consistent and unexpected unusual findings have been recorded and evaluated as to their importance concerning the diagnosis and the ultimate therapy undertaken in each case.

Findings

There were 42 males and 17 females, or a male-to-female ratio of 2.47 to 1, in the series. The age range at time of surgery was 34 days to 44 years with the average age being 19.2 years. Only 9 patients were less than 10 years of age while 8 patients were 30 or more years of age.

Chronologically, the presence of a known systolic bruit or hypertension preceded the diagnosis of coarctation in 24 cases by from 1 to 30 years, with an average of 5.6 years. Five patients had antecedant heart failure occurring at the ages of 1 week, 5 weeks, 17 years, 28 years, and 42 years before the presence of the underlying lesion was detected. In 4 patients the initial symptom of a vascular anomaly was the occurrence of a cerebral vascular accident which ultimately led to a diagnosis of hypertension secondary to coarctation. A single patient had had a previous episode of bacterial endocarditis or aortitis. A diagnosis of previous rheumatic fever had been made by each patient's family

physician in 7 cases, none of which had evidence of active rheumatic disease at the time of corrective surgery. In 5 cases a routine chest x-ray revealed abnormal findings which ultimately proved to be due to coarctation of the aorta.

As might be expected, physical examination led to the diagnosis in the majority of cases. A graphic example is noted in the following case.

> A 19-year-old white male student while undergoing routine physical examination for admission to University Reserve Officers' Training Corps was noted to have hypertension with upper extremity auscultatory blood pressure levels of 160/100. This student confessed to having known hypertension for many years intermittently confirmed by repeated physical examinations. Palpation of peripheral pulses revealed no palpable pulses in dorsalis pedis, posterior, tibial, popliteal, or femoral arteries. There was no obtainable auscultatory blood pressure in the lower extremities. A diagnosis of coarctation was then entertained and ultimately confirmed by further tests.

Since the series includes a predominantly older age group, the presence of visible or palpable collateral vessels over the chest wall was a frequent finding. Collaterals were detected in 36 of the 59 cases and were usually intercostal vessels commonly seen over the back and in the parascapular areas.

Absence of palpable femoral arterial pulsations was recorded in 28 cases (Table 1). In the remaining 31 cases femoral arterial pulsations were present but were felt to be slightly, moderately, or markedly diminished in intensity, often with a detectable lag in their onset when compared to radial arterial pulsations. The presence of pulsations in the dorsalis pedis and posterior tibial arteries was even less frequently detectable, having been absent in 47 cases, while only faintly palpable in the remaining 12 cases. The presence or absence of abdominal aortic pulsations was recorded in 16 cases. No abdominal aortic pulsation was detected in 11 of the 16 cases while in 3 cases it was present but markedly diminished in intensity and in 2 cases it was felt to be normal.

TABLE 1—PERIPHERAL ARTERIAL PULSATIONS

No. of Cases	*Present*	*Absent*
Radial (59)	59	
Abdominal aorta (16)	5	11
Femoral (59)	31	28
Dorsalis Pedis and Posterior Tibial (59)	12	47

Radial pulsations were all felt to be normal and equal bilaterally, with the exception of 2 cases in which there was a marked difference in the intensity of the two sides. A single case with a normal right radial arterial pulsation but with a diminished left radial arterial pulsation was found at surgery to have an aneurysmal dilatation of the left subclavian artery which was resected. In contrast the second case had a normal left radial pulse but an absent right radial pulse. Surgery in this case disclosed a left-sided right subclavian artery coming off of the left side of the aorta just proximal to the coarctation site and passing behind the aorta and across to the right side. The subclavian was then compressed by the aorta as it passed posterior to it, accounting for the absence of a palpable radial pulse.

Thoracic auscultation revealed the presence of audible systolic bruits of varying intensity in all patients. In 44 of the 59 patients these systolic bruits were either most intense in or were transmitted to the interscapular area. In one patient there was a machinery type murmur of maximal intensity in the left second intercostal space which at surgery was proved to be due to an associated large patent ductus arteriosus. Loud diastolic bruits were detected in 7 patients in the series and were noted to occur primarily in the right second intercostal space with transmission along the left sternal border. Also in these 7 cases, a loud diastolic bruit was coupled with a low diastolic pressure and a wide pulse pressure, findings which were thought to be indicative of the presence of a bicuspid aortic valve with aortic regurgitation.

An expected finding was the presence of hypertension in the upper extremities with lowered or undetectable blood pressures in the lower extremities, noted in 51 cases (Table 2). In 8 cases, however, the blood pressure in the upper extremities was considered nor-

TABLE 2—BLOOD PRESSURE LEVELS

	Hypertensive	*Normotensive*
Upper Extremities	51	8
Lower Extremities	(In all cases pressures were undetectable or lower than upper extremity.)	

mal but in each case there was lowered or no demonstrable pressure in the legs. The previously mentioned 2 cases in which there was a difference in radial pulses also had marked differences in auscultatory blood pressures in the upper extremities. The differences were explainable on the basis of the underlying anatomical pathology previously described. The highest recorded blood pressure in this series was 280 systolic and 115 diastolic with the average recorded pressure being 170 systolic and 75 diastolic.

Laboratory tests which may corroborate a diagnosis of coarctation or, more importantly, suggest the presence of an additional lesion are the electrocardiogram, the chest roentgenogram, and direct intra-arterial pressure determinations.

Preoperative electrocardiograms had been taken in 57 of the cases in this series (Table 3). In 25 of these cases the electrocardiogram

TABLE 3—ELECTROCARDIOGRAPHIC FINDINGS

	No. of Cases
Normal	25
Left ventricular strain, hypertrophy or preponderance	21
Incomplete right bundle branch block	3
Right ventricular strain or preponderance	2
First stage auriculo-ventricular block	1
Nonspecific myocardial changes	5
Total	57

was considered normal. In 21 of these cases there was evidence of left ventricular strain, hypertrophy or preponderance. Of more significance, however, was the presence of electrocardiographic evidence suggesting additional hemodynamically significant pathology. Incomplete right bundle branch block was seen in cases of associated ventricular septal defect, auricular septal defect, and large patent ductus arteriosus. Right ventricular preponderance was also seen in the case with an associated ventricular septal defect. Right heart strain was noted in an additional case of associated large patent ductus. A first stage auriculoventricular block was noted in one case with evidence of a bicuspid aortic valve and aortic regurgitation. Nonspecific myocardial changes were also noted in a number of other cases in the series. In no case of uncomplicated coarctation of the aorta did the electrocardiograms disclose other than left ventricular strain, preponderance or hypertrophy, as a significant abnormality.

Chest roentgenograms were of considerable value in this series since it included a predominantly older age group (Table 4). Roentgenographic findings felt to be of significance were: heart size, status of the aortic

TABLE 4—X-RAY FINDINGS

	No. of Cases
Left ventricular enlargement	41
Biventricular enlargement	4
Diminished aortic knob	38
Notched aorta	28
Rib notching	36
Normal	5

knob, notching of the descending aorta, and scalloping of the inferior edges of the posterolateral portions of the ribs. It was felt that the presence of so-called "rib notching" and/or definite notching of the proximal descending aorta was highly indicative if not pathognomonic of coarctation. The presence of aortic and/or rib notching with or without left ventricular hypertrophy and a small aortic knob was noted in 43 of the 59 cases. In 41 cases there was roentgenographic evidence of left ventricular hypertrophy. Biventricular hypertrophy was noted in cases of: (1) large patent ductus, (2) patent ductus with pulmonary hypertension and ventricular septal defect, (3) persistent left superior vena cava and auricular septal defect, and (4) a simple coarctation with associated heart failure in a 34-day-old infant. Three cases with prominence of hilar vascular markings ultimately were proven to have associated cardiovascular defects with left to right shunts.

An extremely unusual finding was the presence of definite rib notching in the chest roentgenogram of a 3-year-old male with a post ligamentum type of coarctation and auscultatory blood pressure levels of 160/100 in the upper extremities (fig. 1).

In 14 cases venous angiocardiography was performed, 9 of which demonstrated a typical constriction in the aorta.

Intra-arterial blood pressure determinations are a valuable adjunct to the diagnosis of coarctation in those patients in whom there is a paucity of diagnostic findings and in those patients in whom the findings sug-

Fig. 1—"Rib notching" (see arrows) in a 3-year-old male with a post ligamentum type of coarctation with blood pressure of 160/100 in the upper extremities.

gest a more significant or additional cardiovascular lesion. Femoral and radial intra-arterial pulse pressures and arterial pulse propagation times were determined in 13 cases in this series. In all 13 cases the systolic and mean pressures in the femoral arteries were reduced below that of the radial or were within the range of normal. The ratio of femoral to radial systolic and pulse pressures in all cases was below the range of ratios in normal subjects. In addition the time of onset of the femoral pulse wave and the time elapsing between the onset and the attainment of the peak in the femoral pulse wave was nearly always beyond the range of values obtained in normal subjects.

Discussion

The male-to-female ratio of 2.47 to 1 is consistent with that reported by others.[1] The preoperative diagnosis of simple coarctation in a 34-day-old infant as a cause of heart failure emphasized that the diagnosis of coarctation in infancy need not be difficult if it is considered during the examination. This patient, whose heart failure failed to respond to medical measures, is now 3 years of age, has a normal blood pressure, and has a normal pattern of growth and development. The successful correction of the coarctation in this case further emphasizes that infancy *per se* is not a contraindication to surgery, as has been previously reported.[2]

Of some significance was the known presence of a systolic bruit or hypertension in 41% of the cases in this series for an average period of 5.6 years prior to the diagnosis of coarctation. The occurrence of a cerebral vascular accident or heart failure in an adult prior to detection of an underlying coarctation as occurred in 7 of our cases is also significant. These findings would indicate that all too often there has been an unnecessary delay in the diagnosis of the lesion. Palpation of peripheral pulses should be a routine part of any physical examination, regardless of the age of the patient. The occurrence of a cerebral vascular accident or heart failure prior to the detection of the presence of an underlying coarctation is deplorable since the lesion is correctable by surgery.

The physical findings in this series were of some interest. The frequent occurrence of physical signs of collateral circulation merely reflected the age group studied. The presence of palpable, although diminished, femoral arterial pulsations in 31 cases in this series re-emphasized that the mere detection of the presence of femoral pulsations does not exclude the presence of coarctation and that it is the intensity of the palpated pulsation which is important. The presence of a diminished left radial pulse secondary to aneurysmal dilatation of the left subclavian was unusual. More commonly a diminished left radial pulse associated with coarctation indicates the presence of the coarctation proximal to the origin of the left subclavian or to hypoplasia or a constriction of the left subclavian at its origin from the aorta. An absent right radial pulse in association with coarctation usually indicates the presence of a left-sided right subclavian which originates from the aorta distal to the site of coarctation rather than proximal as occurred in our case.

The significance of systolic bruits which were detected in all cases is open to question. The presence of a machinery murmur indicated an underlying associated patent ductus, the treatment of which has been thoroughly reviewed by Cooley and co-workers.[3]

A diastolic bruit with a wide pulse pressure indicating the probable presence of a bicus-

pid aortic valve with aortic regurgitation is a finding of some significance. Certainly such a finding is not a contraindication to surgery in the usual case. In 1 of the 7 cases in this series in which aortic regurgitation occurred, a Hufnagel valve was placed in the aorta in the region of the resected coarctation. This patient, who was severely incapacitated, has noted marked improvement since surgery.

The electrocardiogram was of considerable help in the detection of an additional defect in 5 cases in this series. The evidence in an abnormal electrocardiogram of other than left ventricular strain, preponderance or hypertrophy, should be considered an indication for further evaluation of the patient prior to surgical intervention.

The chest roentgenograms were of considerable aid in confirming the diagnosis in the majority of cases in this series, which again is a reflection of the older age range of the patients studied. Evidence of biventricular hypertrophy on the chest x-ray was an indication of an additional defect in 3 of the 4 cases in which it was seen. The fourth case in which it was detected occurred in a 34-day-old infant in heart failure. Prominence of hilar vascularity was noted in 3 cases in which there was a defect with an associated left to right shunt. The finding of rib notching in a 3-year-old patient with coarctation was extremely interesting. We were unable to locate any such case previously reported in the literature.

The intra-arterial pressures and arterial pulse propagation times in this series did not differ significantly from findings reported by others.[4] These findings then require little discussion except to emphasize their importance in the case in which a diagnosis is questioned and in those cases in which additional lesions tend to mask the presence of an associated coarctation.

It is apparent that the finding of unusual physical signs as well as inconsistencies in the expected electrocardiogram and chest roentgenogram may be of utmost significance in the detection of other defects associated with coarctation. It may also be that the coarctation is hemodynamically less significant than the associated defect. Since 1952, those cases of coarctation seen at the University Hospitals in which there were physical, electrocardiographic, or roentgenographic signs indicating the presence of hemodynamically significant associated defects have undergone cardiac catheterization. Intra-arterial pressures and pulse propagation times were usually done at the time of cardiac catheterization.

In the group of cases which had associated cardiovascular defects in this series, there were 6 cases in which the associated defects are currently amenable to surgery. These included large patent ductus arteriosus, ventricular septal defect, auricular septal defect, partial anomalous pulmonary venous connection, and bicuspid aortic valve with aortic insufficiency. In those cases in which there is a significant associated defect, correction of the coarctation alone may not be well tolerated. Such patients deserve a thorough evaluation of the significance of their diagnostic findings prior to consideration of surgical correction of their coarctation.

Summary

The diagnostic findings in a series of 59 cases of proven coarctation of the aorta have been presented and their importance in the ultimate management of the underlying lesion has been discussed. Coarctation of the aorta all too frequently is not diagnosed until it becomes seriously symptomatic. Unusual diagnostic findings may herald an associated cardiovascular defect which is also currently amenable to surgical correction. In those cases in which there is a significant associated cardiovascular defect, correction of the coarctation alone may not be well tolerated and the hemodynamic significance of the associated defect should be properly evaluated.

1300 University Avenue.

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UW COMMITTEE STUDIES DESIRABILITY OF REHABILITATION CENTER

Earlier this year the President of the University of Wisconsin established a special committee to study the desirability of setting up a rehabilitation center at the University under chairmanship of Dr. John Z. Bowers, Dean of the Medical School.

In his charge to the committee the President expressed the feeling of the administrative committee of the University that such a center, if established, should not deal exclusively with medical problems but should encompass all areas of the University dealing with, or interested in, rehabilitation.

Members of the committee are from the College of Letters and Science, Extension Division, School of Education, and the Medical School. Members representing the Medical School are: Dr. John Z. Bowers, Dean (Chairman); Dr. Harry D. Bouman, Professor of Physical Medicine; Margaret C. Crump, Associate Professor of Nursing; and Dr. Nathan J. Smith, Professor of Pediatrics.

The committee has met several times to discuss basic concepts of rehabilitation. During these sessions the committee has raised the point as to whether further development should be in the direction of new facilities (such as a separate rehabilitation center) or in the direction of expansion and possible co-ordination of existing facilities. The committee has also discussed the desirability of an information center on rehabilitation activities in the University and the State.

UNIVERSITY OF MINNESOTA MEDICAL CONTINUATION COURSES

Medical continuation courses to be presented at the Center for Continuation Study at the University of Minnesota are as follows:

January 5–7: Otolaryngology for General Physicians.
January 15–17: Newer Drugs in General Practice.
January 22–24: Surgery for Surgeons.
February 23–25: Cardiovascular Diseases for General Practice.
March 2–4: Pediatrics for General Physicians.

For further information concerning the above courses, write to the Director, Department of Continuation Medical Education, 1342 Mayo Memorial, University of Minnesota, Minneapolis 14, Minnesota.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The next scheduled examinations (Part II), oral and clinical for all candidates will be conducted at the Edgewater Beach Hotel, Chicago, Illinois, by the entire Board from May 8 through 9, 1959. Formal notice of the exact time of each candidate's examination will be sent him in advance of the examination dates.

Candidates who participated in the Part I examinations will be notified of their eligibility for the Part II examinations as soon as possible.

Current Bulletins of the American Board of Obstetrics and Gynecology, outlining the requirements for application, may be obtained by writing to the Secretary: Robert L. Faulkner, M.D., 2105 Adelbert Road, Cleveland 6, Ohio.

CHICAGO POSTGRADUATE COURSE IN ARTHRITIS AND RELATED CONDITIONS

The first Chicago Postgraduate Course in Arthritis and Related Conditions will be given full-time on February 19, 20 and 21, 1959, at Thorne Hall, Northwestern University, Lake Shore Drive at Superior Street, Chicago, Illinois. Tuition: $50.00. Faculty from all Chicago medical schools and six nationally known guest lecturers will be on the program. Frank R. Schmid, M.D., 303 East Chicago Avenue, Chicago 11, Illinois, secretary, will furnish further information upon request.

The Gynecological Examination*

By F. J. HOFMEISTER, M. D., and ROBERT P. REIK, M. D.
Milwaukee

IT IS interesting to note that obstetrics and gynecology have not advanced with general medicine, probably because of false modesty and prudery, all of which have not been overcome even today in spite of the Bikini bathing suits and the trend to near nudism in dressing. The vaginal examination and inspection of the genitalia are still considered too great an infringement on the woman's person.

Obstetrics, as we know it, is a product of the twentieth century, especially of the past 30 years. It was not until the middle of the nineteenth century that the male—in the form of a physician—was accepted. The midwife ruled previously.

In 1850, James P. White, professor of obstetrics at Buffalo Medical College, exhibited a laboring woman to the members of the graduating class. A storm of controversy arose over this unprecedented procedure and protests poured in from all sides.[1] The members of the committee on education of the American Medical Association condemned the practice and rebuked Professor White.[2] The rebuke stated that the only conceivable advantage gained by omitting the customary full drapes was somewhat greater facility in protecting the perineum; but this did not compensate for the obvious disadvantages of the method, since it was considered that a physician who was not prepared to conduct labor by sense of touch alone was not competent to practice obstetrics.

Gynecology was as greatly retarded, and Doctor Meigs of Philadelphia indicated that the vaginal examination might induce a lax moral sense in patients.

As late as 1934–35, it was not unusual for a hospital house staff physician to be refused permission to take the history of select female patients in some Milwaukee hospitals. It has been only in the past 10 years that the house staff has been permitted to do a gynecological examination on private female patients.

It was in 1917 that the influence of hormones on vaginal mucosa was studied by Papanicolau. As an outgrowth of this study, Papanicolau in 1939 reported his work with cytology as an aid in the diagnosis of carcinoma. Gradually this has been accepted as a valuable routine procedure in gynecological diagnosis. It was the recognition of the value of the Novak and Randall curette to clinical gynecology that has made these instruments, which were devised for research, into valuable aids in gynecological diagnosis.

Today the gynecological examination is no longer composed of an intelligent look on the face of the physician who, while scanning the ceiling for an inspiration, ruthlessly probes and pushes the vagina with the characteristic two examining fingers. Nor is gynecology characterized by a pompous physician who gages his success by a pile of uteri and ovaries that surround him.

The following description attempts to clarify the minimum that should be expected by a woman when she submits to a gynecological examination.

Gynecological Examination

A gynecological examination is the evaluation and examination of the entire woman. Every initial and routine examination of a woman should be done with this completeness. This routine procedure should vary only in some age groups, especially the very young, and where the gynecological examination is complicated by pregnancy.

1. Instruments: Minimum equipment must include a correctly-sized speculum, materials for taking Papanicolau smears and routine vaginal smears, and instruments for obtaining cervical and endometrial biopsies. (Fig. 1).

Every physical examination must be preceded by a complete and accurate medical history. This is the key to any diagnosis. Though the history should be all inclusive, of particular importance is an appraisal of the menstrual experiences. Some of the most important questions that must be asked are those concerning age of onset, length of in-

*Based on the First Award Exhibit at State Medical Society of Wisconsin annual meeting May 7-8-9, 1957.

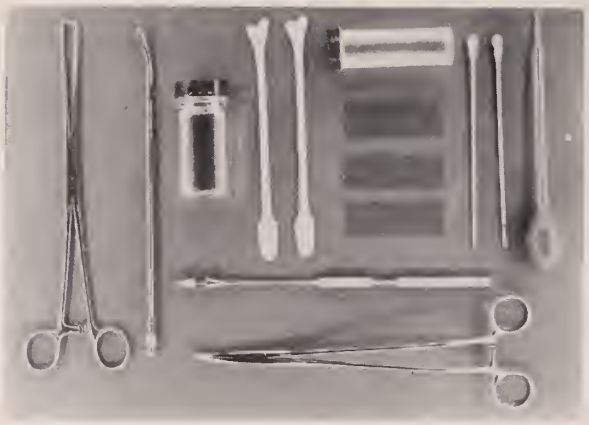

Fig. 1—Instruments.

terval between periods, duration of flow, quantity of flow as estimated by the number of pads stained or saturated, and presence of pain.

The physical examination must include all the areas from head to toe. It is our purpose to discover, if possible, any or all existing pathology, even unrelated to gynecology. Among the areas of special significance are the *neck*, the *blood pressure*, the *back*, the *heart*, the *lungs*, and *especially the breasts*.

The gynecologist has the greatest opportunity of any physician of detecting early lesions of the breast. In 4,418 patients routinely examined, 60 lesions were found, 12 were malignant.

2. Palpation of Breast: The patient is requested to bend forward from the hips, to extend her head and to extend her arms. In this way asymmetry and retraction can be noted.

The breast is then examined with the patient in a sitting position. (Fig. 2). The flat of the hand creates gentle pressure against the rib cage. First, the area between the sternum and the nipple, and then the lateral area is palpated with the flat of the hand. This is repeated with the patient in the supine position. The arm is kept at the side while the lateral area is examined; it is

Fig. 2—Palpation of breast.

raised above the head when the medial area is palpated.

Any mass that is found is evaluated for fixation to the skin or muscle. If a mass is found, the axillary areas are carefully palpated for evidence of glands.

Careful pressure is placed on the breast tissue toward the nipple area to determine if fluid can be expressed. A Papanicolau smear can be made of this secretion.

The abdominal and flank areas must be carefully appraised.

The distribution of the pubic hair is noted.

The extremities are evaluated for varicosities and edema.

Before starting the examination of the genitalia, both bladder and bowel should be emptied.

Fig. 3—Inspection of external genitalia.

3. **Inspection of External Genitalia:** The external genitalia are carefully inspected. (Fig. 3).

The patient is requested to bear down. The effect of this strain upon the area of the vagina adjacent to the bladder and the rectum is noted.

If possible, visualization of the cervix is also noted, when the patient strains.

The Bartholin glands are palpated and the Skene glands evaluated.

4. **Speculum:** With the patient bearing down, a nonlubricated speculum is inserted diagonally, in order to avoid the discomfort of trauma, to the uretheral area. (Fig. 4). Lubrication is avoided so that the foreign material will not interfere with the interpretations of the vaginal smears.

The patient has been instructed not to douche or use vaginal medication for several days before the date of her appointment. Medications could interfere with accurate reading of vaginal smears.

Fig. 4—Speculum.

Fig. 5 (a) (b)—Papanicolau smear slide.

5. **Papanicolau smear slide:** With an Ayre spatula or an aspiration bulb, material is gathered for Papanicolau smears. (Fig. 5). The material is immediately placed on slides which are placed back to back in 70% alcohol. Drying should never be permitted. These smears are submitted to adequately trained personnel for interpretation. A routine vaginal smear is also taken.

There should be no definite cervical therapy, such as cautery, and no pelvic surgery until an interpretation of the Papanicolau smear is obtained. Routine cervical or vaginal pool Papanicolau smears will reveal endometrial pathology in only 50% of the instances as compared to 95% in cervical pathology. The cervical or endometrial smear is merely a method of creating suspicion. Verification must be effected by adequate biopsy. Where suspicious endometrial patterns are obtained the patient must be admitted to the hospital for adequate dilatation and curettage.

6. **Use of Novak Curette:** With the initial examination of every adult, with every routine yearly examination on patients above the age of 35, or when irratic bleeding has occurred, an appraisal is made of the endometrial cavity with an endometrial curette of the Randall or Novak type. (Fig. 6). This tissue is immediately placed in a formaldehyde solution and sent to the laboratory for interpretation. If the curette is withdrawn and no tissue is seen in the mouth of the curette, the secretion is blown on slides and prepared as Papanicolau smears. In some instances it is advantageous to use the Clyman cannula for aspiration of endometrial secretion for Papanicolau evaluation.

7. **Vaginal Examination:** The gynecological examination is completed with an accurate digital evaluation of the vagina, mobility of the cervical area, the parametrial area, the adnexal area, and the fundal area by routine abdominovaginal examination. (Fig. 7).

8. **Rectovaginal-Abdominal Examination:** Every examination must include the rectovaginal-abdominal examination. One of the most valuable additions to the pelvic examination is gained as a result of inserting a finger into the rectum. The entire posterior uterine area, the adnexal areas, and the cul-de-sac areas along with the anal-rectal areas are easily palpated. (Fig. 8).

9. **Biopsy:** Where a highly suspicious cervical lesion is present or where suspicious or positive Papanicolau patterns are obtained in the cervical Papanicolau smears, cervical biopsy can be done as an office procedure. However, it must be adequate. Although the four quadrant biopsy has been recognized

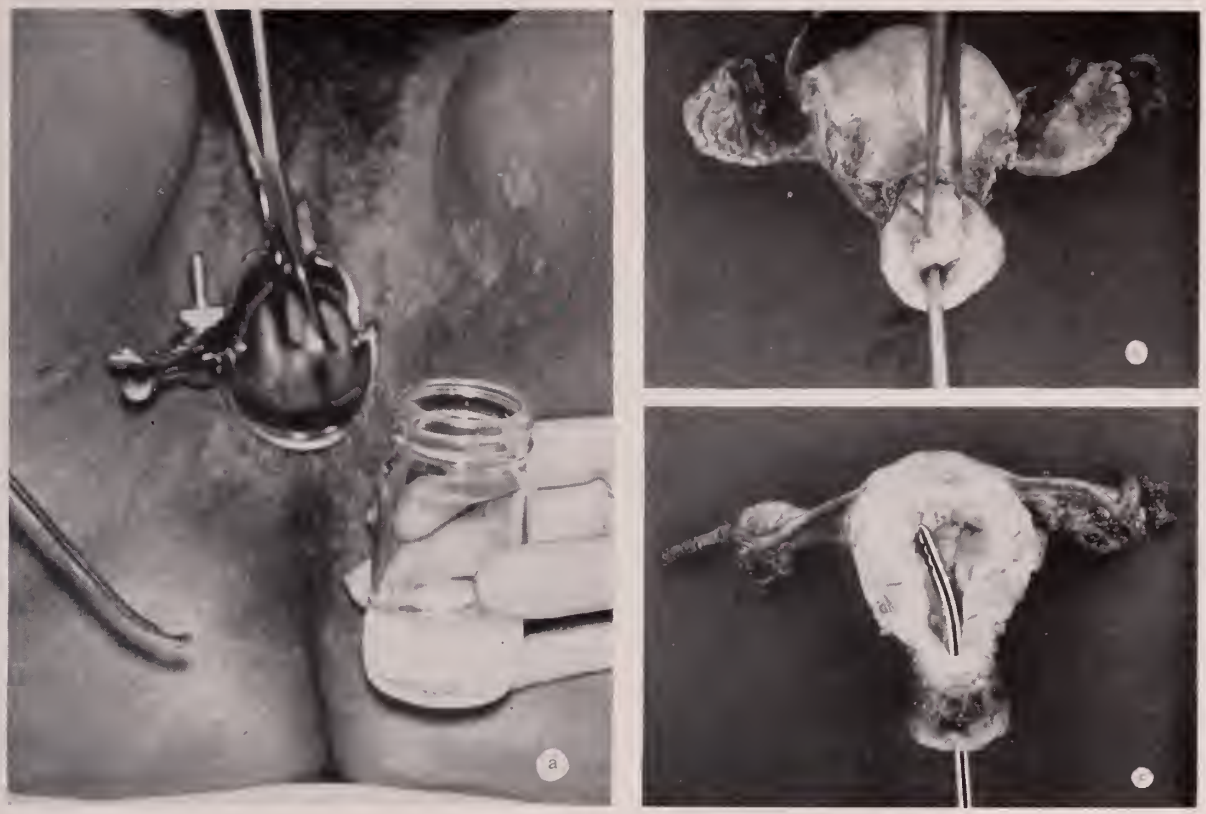

Fig. 6 (a) (b) (c)—Use of Novak curette.

Fig. 7—Vaginal examination.

Fig. 8—Rectovaginal–abdominal examination.

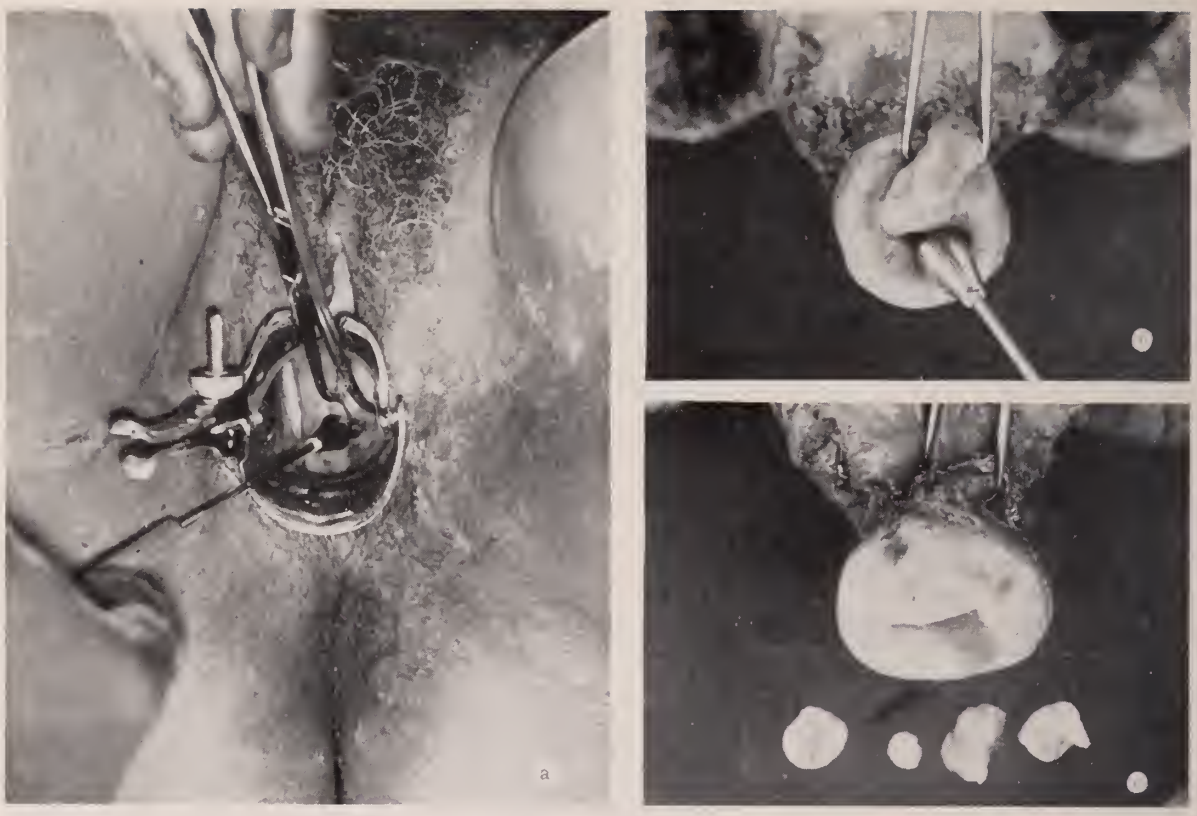

Fig. 9 (a) (b) (c)—Biopsy.

as adequate, its value will be greatly enhanced if the biopsy includes the entire squamo-columnar junction. We use the Gusberg instrument; and though four segments are taken, these segments overlap and the entire circumference is obtained. (Fig. 9). The punch biopsy instrument may be used if the material obtained includes the entire squamo-columnar junction. If this tissue is interpreted as positive, adequate, accurate therapy can be instituted immediately. If further verfication is deemed advisable, adequate, accurate therapy can be instituted immediately.

This completes the gynecological examination along with such routine laboratory tests and special laboratory examinations as advised when indicated. A tampon is inserted to prevent the patient from soiling her clothes and the patient is instructed to remove this tampon within six hours.

It is gratifying to know that the patient will have been given every opportunity of receiving accurate and rapid therapy where pathology exists, or the assurance of a state of well being where all is found to be normal.

Early recognition of unsuspected lesions by routine complete gyneocological examinations will increase the cure rate in malignancy from the present 25% and 35% to 80% and 85%. Remember that every gynecological examination should be approached as an appraisal of the entire woman.

If this is done we will answer the appeal made by John A. Sampson, in 1907, for early diagnosis—"in order to achieve prophylaxis of the incurable stage".[3] This he said, "can come only by education of both physician and patient, the former first, and to him this contribution is offered."

(F.J.H.) 2212 West State Street.

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Roentgen Detection of Early Gastric Neoplasm

Report of a Case

By LLOYD K. MARK, M. D.*
Milwaukee

THE early diagnosis of gastric neoplasm remains a major problem in medicine today. The appallingly low five-year survival rate indicates public and medical neglect in ferreting out this disease. Usually by the time the tumor is found the patient has already tried self-medication or has been treated by his physician for supposedly minor digestive or nervous disorders. During this fatal period of symptomatic therapy when the patient's symptoms mimic those of benign illness and are not indicative of neoplastic disease, the tumor frequently grows beyond the limits of surgical cure. Occasionally, however, in spite of early clinical suspicion and careful roentgen examination, the tumor escapes detection and is discovered only after widespread growth and incurability.

Combined with clinical awareness, upper gastrointestinal x-ray examination offers the best means of diagnosing early gastric neoplasm. By meticulous fluoroscopy and multi-positioned radiography the entire stomach can be examined. At the fluoroscopic examination gastric tonus and peristalsis are determined visually and manually. Abnormal or suspicious areas are recorded immediately on spot film radiographs. Supplementing the fluoroscopic impression are radiographs of the stomach and adjacent regions which provide further detail and perspective.

Large gastric tumors are readily evident. Polypoid lesions protrude intraluminally. They indent irregularly the barium column and distort the mucosal pattern. Infiltrative tumors indurate the wall, impair peristalsis, and narrow the gastric lumen. Both types may ulcerate.

With present roentgen techniques, small tumors of the stomach often defy detection. Polypoid lesions may become obscured by the contrast medium. In these instances radiographs depicting mucosal pattern and offering double contrast studies (barium and air) are of extreme importance.[1,2] The tumor, thinly coated by barium, may then be seen clearly contrasted against a radiolucent air background. On the other hand, small infiltrative tumors, unless they impair peristalsis or narrow the gastric lumen, remain undetected. Occasionally digital palpation of the abdomen at the time of fluoroscopy will elicit localized induration of the stomach wall and spot film radiographs of this region indicate slight distortion and rigidity. These x-ray findings, often simulating the appearance of gastritis and other benign lesions, are frequently insufficient to warrant a diagnosis of tumor, and require further evaluation by gastroscopy and by repeated upper gastrointestinal x-ray examinations.

Of particular problem in x-ray diagnosis are lesions of the gastric fundus and cardia. This region, inaccessible to palpation due to overlying bony structures, is widely variable in its normal appearance.[3] When incompletely distended with contrast medium, its mucosal pattern often appears coarsened and irregular and simulates the type of distortion produced by tumor elsewhere in the stomach; when fully distended with opaque media its intraluminal detail becomes obscured. Small polypoid tumors may often be detected on the double contrast studies by their intraluminal protrusion and thin barium coatings. If strategically located at the cardioesophageal orifice, they will frequently divert or split the barium stream as it enters the stomach. Small infiltrative tumors of the cardia and fundus offer no distinctive clues. Here neoplasm, gastritis, giant gastric rugae, and extrinsic pressure from adjacent organs mimic each other on the x-ray.

The following report of a case concerns a patient with an extensive tumor of the stomach, which while undetectable on the x-ray at the first examination, was seen to be very extensive six weeks later. This case grimly illustrates the insidious and lethal rapidity with which gastric tumors can grow, and the inherent difficulties of early x-ray diagnosis.

* Associate Radiologist, Department of Radiology, Mt. Sinai Hospital, Milwaukee, Wisconsin.

Fig. 1—Slight coarsening of the gastric mucosa along the posterior wall of the fundus, suggestive of gastritis (arrow).

Fig. 2—Six weeks later, extensive tumor involving the entire length and thickness of the gastric wall.

Report of a Case

A 43-year-old white housewife was admitted to the Michael Reese Hospital for diagnosis and treatment of severe iron deficiency anemia. Four months previously she had first noticed malaise, abdominal distress, and headaches. Her symptoms were intermittent and presumed secondary to emotional distress, produced by her only child's frequent illnesses. Several examinations by her physician failed to disclose evidence of organic disease. Upper gastrointestinal x-ray examination on May 16, 1956, revealed slight coarsening of the gastric folds along the posterior wall of the fundus (fig. 1.). This finding, though suggestive of localized gastritis, was considered of borderline significance and probably normal. Because her red blood cell count was 3,200,000 and her hemoglobin 7.9 gm., iron therapy was started and she was discharged. She tolerated this medication poorly, experiencing frequent episodes of abdominal cramps and vomiting. Following an episode of hematemesis with fainting, she was again hospitalized. Upper gastrointestinal x-ray examination on June 27, 1956, six weeks following the previous study, revealed an extensive infiltrative and polypoid tumor involving the entire stomach (fig. 2).

A total gastrectomy was performed. The stomach, completely enveloped by tumor, was firmly adherent to surrounding tissue so that in spite of careful surgical dissection, tumor was left on the pancreas. In order to free the cardia, the spleen was also removed. At the time of surgery, there was no gross evidence of lymph node or liver metastases. Microscopically, the extirpated stomach revealed a primary adenocarcinoma involving the entire thickness of the wall and infiltrating attached mesentery and adjacent lymph nodes. Similar tumor cells were visible at the edges of the resected specimen.

Comment

Undoubtedly the small areas suggestive of gastritis, seen on the first x-ray study, were already involved by tumor. Either the neoplasm was still localized in this region or, as is more likely, was already widespread but had not yet sufficiently infiltrated the stomach wall to impair gastric tonus and disturb peristalsis. This initial roentgen finding was not enough to justify a diagnosis of tumor. Yet six weeks later its true significance became apparent.

The interpretation of apparently insignificant or borderline x-ray findings is a problem all radiologists frequently face and is one that puzzles the most astute and experienced observer. The radiologist's first reaction is to

interpret such findings as "within normal limits" or as "normal variants." To ignore them may be sidestepping the core of the patient's illness and may prevent curative therapy. To incriminate them as definite disease may arouse needless anxieties and often involve hours of intensive, fruitless investigation. The only course available is a highly individual evaluation of each patient. Unless certain of the insignificance of the roentgen findings and particularly if the clinical evidence remains suggestive, the roentgenologist is obligated to advise early and frequent x-ray follow-up examinations.

Summary and Conclusions

Upper gastrointestinal x-ray examination affords the best method of detecting early gastric neoplasm. By careful fluoroscopy and radiography, most small tumors can be detected either as polypoid lesions protruding intraluminally or as infiltrative growths indurating the wall of the stomach and narrowing its lumen. Tumors of the cardia and fundus are particular problems due to the variable normal configuration of its mucosal pattern, extrinsic pressure from adjacent organs, and overlying structures rendering this area inaccessible to palpation. A case is presented where a small tumor of the fundus, initially showing trivial and questionably significant x-ray changes, apparently spread in six weeks to involve the entire length and thickness of the stomach wall. This case graphically illustrates the urgency and difficulties of early x-ray diagnosis and the need of roentgen and clinical follow-up examinations in the face of such equivocal x-ray findings.

Mt. Sinai Hospital.

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GRADUATE FELLOWSHIPS OFFERED IN INDUSTRIAL MEDICINE

The University of Cincinnati's Institute of Industrial Health is offering graduate fellowships in Industrial Medicine. The Institute, which is in the College of Medicine, provides professional training for graduates of approved medical schools who have completed at least one year of internship.

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A one-year course is also offered to qualified applicants who may be candidates for the Master of Science degree.

Requests for additional information should be addressed to: Secretary, Institute of Industrial Health, College of Medicine, Eden and Bethesda Avenues, Cincinnati 19, Ohio.

SEVENTH ANNUAL CANCER SEMINAR AT PHOENIX JANUARY 22–24

The Arizona Division of the American Cancer Society will be host to the seventh annual Cancer Seminar to be presented January 22, 23 and 24, 1959, in Phoenix, Arizona, at Paradise Inn. A nurses' program will be held in conjunction with the Seminar on January 24. Nurses will also be welcome to attend any portion of the Seminar.

For further information write to: American Cancer Society, Arizona Division, 543 East McDowell, Phoenix, Arizona.

3
Institutes on Maternal Deaths Scheduled for January

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Associate Clinical Professor of Obstetrics and Gynecology
Marquette University School of Medicine, Milwaukee

WILLIAM KREUL, M.D.
Past President, Wisconsin Society of Anesthesiologists
Anesthesiologist, St. Luke—St. Mary Hospitals, Racine

T. A. LEONARD, M.D.
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Pruritus Vulvae

Clinical Review of 50 Cases

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THE term "pruritus vulvae" is one that describes a symptom and is not a clinical diagnosis. This accounts for some of the confusion that arises when this term is used as a clinical diagnosis, especially in such cases as psoriasis and trichophytosis of the vulva. Dermatologists are aware of the misnomer and use the term only as a symptom. However, some practitioners, gynecologists, and radiologists use this terminology even when there is acute inflammation present.

The purpose of this paper is to review the various conditions that cause the symptom of pruritus vulvae and to point out that it is fairly common and often difficult to treat. Therefore the treatment is discussed. I have reviewed the clinical manifestations in a series of 50 patients seen in my dermatological practice.

General Considerations

Pruritus vulvae is rarely seen without dermatitis, excoriation, or thickening of the mucosa. The vagina is seldom involved unless there is a primary vaginitis which may cause, in addition to the pruritus, dermatitis of the vulva. Over 50% of the patients in this series were worried about cancer and 3 had definite cancerphobia.

It is impractial to estimate the portion of cases due to any given cause because of the variation in clinical material seen by observers in different specialties and because of different interpretations. (For example: If there is a vaginitis or infection present and it has preceded or followed the pruritus, one might conclude that numerous patients have vaginitis as the cause of pruritus.) Infection may cause vaginal discharge and may irritate the vulva as with cystitis, urethritis, cervicitis, or proctitis. Poor hygiene may do the same, as may trichomonad or monilial infection. Cystocele, rectocele, or prolapse may cause vaginitis, even without urinary infection or incontinence. Pregnancy, diabetes, and senility may also cause vaginal changes favorable to infection or discharge.

Pruritus ani frequently extends over the perineum and on to the vulva. In such cases when one does not know where the eruption began, one must consider the local etiological factors of pruritus ani such as anal pathology, infestation, or rectal disease. Vulvar itching is a symptom of many dermatoses which may produce clinical features of pruritus vulvae. Correct diagnosis is not difficult when the pruritus is a symptom of a more extensive dermatitis, such as neurodermatitis, lichen planus, lichen sclerosus, seborrheic dermatitis, psoriasis, trichophytosis, or scabies; or when it is caused by infestation such as pediculosis. Differentiation may be difficult when psoriasis is limited to the vulvar region, especially when dermatitis or mycotic infection mask the correct diagnosis. Several gynecologists in reviewing these cases called lichenified eczema, which caused a thickening and excoriation of the vulva, leukoplakia. Some of these patients also received x-ray treatment at the hospital. We believe that if the pruritus is severe enough to justify x-ray therapy, a dermatologist should see the patient.

We must also keep in mind that local applications of some medications may irritate the vulva, especially the "caine" group such as procaine and surfacaine. Many of these patients have overtreated themselves with various proprietary preparations. Other contact factors that may play a part in the cause of this condition are contraceptive creams, douches, condoms, deodorants, perfumes, nail polish, hygiene pads, and various types of contact dermatitis due to plants and weeds such as poison ivy.

I wish to point out that there is a relationship between tension and pruritus. Sulzberger and Baer[1] and others have written about this, and physicians should keep these psychological factors in mind. The physician should interpret the physical, mental, and

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emotional behavior of patients in the light of current thoughts on psychosomatic medicine. No one doubts the frequent association of tension and pruritus, but views differ as to their sequence. Tension often follows chronic vulvar pruritus and influences the general and sexual behavior of the patient. We believe that physiological factors also influence the course of the eruption. Experiments have shown that psychic tension can initiate itching and modify physiological processes, such as sweat and oil glands functions and vasomotor phenomenon that relate to edema. The emotional state of the patient may cause some or all of the symptoms in some cases.

Marital discord, unsatisfactory sexual life, frigidity, and other psychic factors in the sexual sphere may be a cause of the condition.

REVIEW OF CASES

The records of 50 patients with pruritus vulvae, seen during the past five years, were reviewed with regard to cause, nature, and course of this disease as seen in private dermatological practice. I excluded vulvar itching associated with more extensive eruptions, such as psoriasis, neurodermatitis, and the like. However, I included in the study those cases of localized neurodermatitis limited to the vulvar, perianal, or perineal areas and those cases of psoriasis and seborrheic dermatitis that were limited to these areas. One realizes the importance that the symptoms of vulvar pruritus play, especially in some generalized and widespread conditions of atopic eczema, neurodermatitis, psoriasis, and the like. In my series of cases there were no cases of parasitic infection, such as scabies or pediculi pubis.

Age of Onset

In this series of cases the largest number of patients was in the age group from 30 to 39 years old, followed by the age group of 40 to 49 years, and then 50 to 59 years. This was analyzed because of the frequent emphasis on climacteric factors compared with such factors as atopy as a control. This is in keeping with Lynch's[2] report on pruritus vulvae; in a series of 112 cases, 30% of his patients were in the age group of 30 to 39.

Age (years)	*Number of Patients*	*Per Cent*
20–29	5	10
30–39	13	26
40–49	12	24
50–59	10	20
60–69	7	14
70–79	2	4
94	1	2

Marital Status

It was interesting to survey the marital status of these patients as the greatest incidence of pruritus vulvae occurred in the married group which made up 74% of the cases. Fourteen per cent of the cases of pruritus vulvae were seen in single individuals, 8% in widows, and 4% in divorcees. It is interesting to note that several of the cases of pruritus vulvae were due to contact dermatitis in which there was sensitivity to douches and vaginal creams. Several of the patients who were widowed were in the older age group and atrophy of the vulva played an important part.

	Number of Patients	*Per Cent*
Single	7	14
Married	37	74
Widowed	4	8
Separated	2	4

Catamenial Data

In reviewing the menses with reference to pruritus vulvae, normal menses were present in 36% of the patients. Though endocrine factors have often been emphasized in relation to pruritus vulvae, the association of the onset of the symptoms with pregnancy, scant or irregular menses, climacteric symptoms, or in the postmenopausal patient is not necessarily of etiological significance. In this series the onset was postmenopausal in 20 patients, or 40%. Climacteric symptoms were present in 6 patients, or 12%, and in 2 patients, or 4%, the onset was during pregnancy. In the cases associated with pregnancy the mechanical or infectious features were more significant than the endocrine features. Among the patients having menses there were a few with irregular or scant flow.

Menstruation	*Number of Patients*	*Per Cent*
Normal	18	36
Irregular	4	8
Pregnant	2	4
Climacteric	6	12
Postmenopausal	20	40

Duration of Symptoms

Duration of symptoms was of interest not only with reference to the amount of dermatitis present, but also with reference to the severity of the condition. In those cases of less than one month duration, which constituted 14%, the vulva was usually moist and edematous and moderately inflamed, while in those of longer duration the vulva was dry and thickened. Several of the patients had, from their description and history, mild dermatitis at the onset; but they were somewhat hesitant about seeking medical advice and applied various ointments which in most cases were irritating. In reviewing the figures on duration of symptoms, it was found that 16% of the cases were in the three-to-four-month group and 16% in the one-to-two-year group. Response to treatment was almost directly proportional to the duration of symptoms at the time dermatological treatment was sought.

	Number of Patients	*Per Cent*
Less than 1 month	7	14
1 month to 2 months	6	12
3 months to 4 months	8	16
5 months to 6 months	4	8
7 months through 11 months	7	14
1 year to 2 years	8	16
2 years to 3 years	3	6
3 years to 4 years	3	6
5 years	1	2
6 years	1	2
7 years	1	2
8 years	1	2

Involvement

Eighty-four per cent, or 42 of the patients, had vulvar involvement only while 16% had involvement of the vulva, anal, and perineal areas. It was difficult in many of these cases to determine exactly whether or not the eruption started in the anal area and then spread to the vulvar area. However, most of the patients stated that the first sign that they had of the condition was pruritus of the vulvar area.

	Number of Patients	*Per Cent*
Vulvar only	42	84
Vulvar and anal	8	16

Nature of Eruption

Most of the conditions were long standing and were dry, papular, or thickened; this occurred in 72% of the cases. Another 20% were more moist and eczematoid and weeping. Eight per cent of the cases were severe with marked edema and weeping. The last two groups consisted mostly of the contact type of dermatitis.

	Number of Patients	*Per Cent*
Dry (papular or thickened)	36	72
Moist (eczematoid)	10	20
Moist and edematous	4	8

Diagnosis

One of the most important studies was the diagnosis of the condition causing the pruritus. One can summarize the findings by stating that 24 cases, or 48% were diagnosed as localized neurodermatitis. You will recall that we omitted from the study all cases of generalized neurodermatitis or widespread neurodermatitis with local involvement of the vulva. In these cases we found that the individuals were nervous and tense, many of them distraught, and some of them unhappy, with several cases of marital discord obvious. They stated that their first symptom was that of itching and in response to the itching they would scratch and rub the area and in that way set up a scratch habit eczema.

This scratch habit pattern often sets up a vicious cycle, as frequently after the patient has scratched the area that has itched a great deal, a dermatitis develops consisting of redness, edema, and weeping, together with the excoriation. Secondary infection frequently follows and this also itches a great deal. When treatment is instituted this scratch habit pattern is often broken and the itching decreases tremendously as the dermatitis subsides.

We found that most patients with localized neurodermatitis smoked more than a pack of cigarettes a day, drank more than three or four cups of coffee a day, and admitted that itching was worse when they were under special types of nervous strain.

Moniliasis is also an important causative factor. In this condition there were gray, milky, film-like patches present on the labia majora and minora and several of these patients had a monilial vaginitis. Vesiculopustular lesions were often present at the margin

of these gray patches as satellite lesions. Some had involvement of the groin, perineum, and perianal area with scattered vesiculopustular lesions. There were 2 cases of fungus infection with involvement of the perianal and perineal areas with sharp red vesicular margins and clearing in the center. Kraurosis vulvae was seen in which there was atrophy of the external genitalia, mild contraction of the vaginal orifice, and formation of leukoplakial patches on the mucosa. Several patients had Trichomonas vaginitis causing involvement of the vulva with redness, edema, and weeping. Two patients were diabetic and they had localized thickening, redness, and excoriation of the vulva as a result of scratching the area in response to the itching.

Leukoplakia was present in the older age group together with senile atrophy. There were 2 cases of localized seborrheic dermatitis involving the vulva and pubic area with scaling and redness in this series; and one patient had two patches of typical psoriasis present on the genitalia with mica red scaly lesions and a pink discoloration with thickening of the perianal area. One case of contact dermatitis due to poison ivy and limited to the genitalia and one case of fixed dry eruption due to Ex-lax in which the phenolphthalein was present were recorded.

	Number of Patients	*Per Cent*
Neurodermatitis	24	48
Moniliasis	6	12
Kraurosis Vulvae	4	8
Vaginitis	3	6
Trichophytosis	2	4
Diabetes	2	4
Leukoplakia	2	4
Senile Atrophy	2	4
Seborrheic Dermatitis	2	4
Psoriasis	1	2
Contact Dermatitis	1	2
Fixed Drug	1	2

The above mentioned causes of the symptom of pruritus vulvae as diagnosed in the series of cases studied varies greatly from the causes listed by Karnaky.[3] In reviewing 1,422 cases of pruritus in his gynecological practice, he found Trichomonas vaginitis and fungi as the cause of 97% of pruritus vulvae.

Therapy

The treatment of pruritus vulvae depends upon the proper diagnosis of the condition. Appropriate treatment cannot be instituted unless the proper diagnosis is made. In the case of acute dermatitis the application of wet dressings, such as Burow's solution twice a day for an hour each or sitz baths in Burow's solution, is of great value. The application of a lotion such as calamine emulsion, consisting of calamine 12, lanolin 10, olive and lime water in equal parts for quantity sufficient to make 180 cc., is very beneficial. One may also add ½% menthol or ½% phenol to the lotion as antipruritic agents. Those patients who have an acute vaginitis due to trichomoniasis or to Monilia must also be treated with appropriate douches so that the underlying infection can be eradicated. In cases of trichophytosis or moniliasis one must also make certain that there is no vaginal moniliasis present; and if it is present, it should be treated with appropriate douches such as potassium permanganate douches 1:10,000 or lactic acid. Potassium permanganate 1:10,000 in a sitz bath twice a day for one half hour each, or wet dressings consisting of potassium permanganate 1:10,000 twice a day for an hour each are beneficial. If the moniliasis is moderately severe, one can add 2% or 3% sulfur to the calamine emulsion. Later on when the acute phase has subsided a preparation such as 2% sulfur in zincundecate ointment is beneficial, as is nystatin ointment. We have found that nystatin lotion and nystatin ointment used in the acute edematous phase is often irritating, but it is of great benefit after the acute phase of weeping and edema has subsided and the condition is dry and scaly. It is most beneficial in the chronic type that tends to recur. It is important to determine if the patient has diabetes. The drier thickened types of pruritus vulvae, such as neurodermatitis, seborrheic dermatitis, and psoriasis can be treated with appropriate local preparations, such as 1% hydrocortisone in aquaphor; dimethisoquin lotion and cream together with dyclonine cream is also beneficial.

In psoriasis, it is most beneficial to use a preparation such as 4% ammoniated mercury, 1% salicylic acid in white vaseline; and for seborrheic dermatitis 3% iodochlorhydroxyquin, 2% naftalan in aquaphor.

All of these patients must be treated with general supportive and hygienic measures, intelligent and cautious topical therapy, and limited use of roentgen therapy. A nonspecialized, family doctor type of psychotherapy

is also beneficial in many cases of neurodermatitis. One must use certain psychological approaches in trying to determine what is the cause of the neurodermatitis and try to help the patient relieve his state of nervous tension, stress, or strain. All of these cases are usually benefited by elixir phenobarbital, a teaspoonful three or four times a day, or the combination of elixir phenobarbital and elixir diphenhydramine. Many of the patients who noticed that their itching was much more severe prior to or after the menstrual period benefit by taking estrogens by mouth.

Both of the patients with senile atrophy were treated cautiously with estrogenic hormones by a gynecologist and they were relieved of their pruritus.

Summary

The records of 50 patients observed in private dermatological practice were reviewed with reference to age of onset, marital status, catamenial data, duration of symptoms, involvement, nature of the eruption, diagnosis, and treatment. Emphasis was placed on proper management, proper diagnosis in order that proper treatment could be instituted, and a warning given of the dangers of applying sensitizing agents to the already inflamed areas.

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WMA DOCTORS CONSIDER EFFECTS OF NUCLEAR RADIATION

The General Assembly of The World Medical Association was the first group of doctors to consider the biological effects of nuclear radiation after the issuance of the report of the United Nations Scientific Committee.

At the request of many of its 55 member medical associations, The World Medical Association initiated a campaign designed to keep the medical profession in every country fully informed on the effects of nuclear radiation. One of its first actions in this campaign was in securing Dr. Louis M. Orr of Orlando, Florida (USA), Consultant to the Institute of Nuclear Studies, Oak Ridge, Tennessee to address the XIIth General Assembly of the Association on the subject *"The Biological Effects of Nuclear Radiation"*.

Doctor Orr prepared his address and was in Denmark when the long-awaited report of the United Nations was made public.

Doctor Orr reported:

"It is known that radiation can be dangerous but *fire* can be dangerous also. It is a matter of control. It is a fact that for centuries mankind has lived with an amount of radiation some thirty times greater than the fallout to this date from nuclear tests. It is also a fact that modern man has received a great deal more radiation over his entire body from x-ray and fluoroscopic examination than from nuclear fallout.

* * *

"In the medical profession it is known that radiation is an effective treatment for certain diseases and a necessary accompaniment of important diagnostic procedures. It cannot be discontinued nor should it be indicted indiscriminately. It is necessary to evaluate potential *dangers* against possible benefits."

U. N. Report states:

"Some hazards are implicit in almost all technological advances," but radiation exposure in x-ray diagnosis and treatment, as well as in research and industry, are "for the benefit of mankind and can be controlled." In this respect the Committee drew a sharp distinction between hazards undertaken voluntarily and hazards imposed on all the peoples of the world without their consent.

Obstetrical Anesthesia

By WILLIAM KREUL, M. D.*
Racine

THE problem of maternal death due to aspiration of vomitus during general anesthesia for obstetrical delivery has received nationwide attention and has been the cause of death in several cases studied by the Wisconsin Maternal Mortality Survey Committee. A thoughtful contemplation of these cases has led to some implied, some immediate, and some related considerations.

What of preventability? Do Wisconsin doctors tell the pregnant woman about food intake in relation to her labor and delivery? If so, is she likely to disregard her doctor's advice? Having done so, does the obstetrician ask her, or have the hospital personnel ask her, when and what food she took? With that knowledge on hand is the obstetrician equipped and mindfully disposed to use other than a general anesthesia?

What of responsibility? Unless another doctor administers the anesthesia, the responsibility rests squarely with the attending obstetrician. This should prompt everyone concerned to pause long enough to consider what steps may be taken to prevent unnecessary maternal deaths. The knowledge needed to discharge this responsibility is not great. Fundamental concepts, with an overlay of specific information, will go a long way to insure obstetrical patient safety in anesthesia.

First, consider the immediate problem of the full stomach. Regardless of the type of anesthesia proposed, every obstetrical patient as part of her indoctrination should be advised and instructed to refrain from eating after the onset of her labor. Even when a local or regional anesthesia is anticipated, no one can guarantee that some situation requiring a general anesthesia will not arise. Besides, and this is the crux of the matter, why place foodstuffs in a non-functioning stomach? *Once the uterus starts contracting, the stomach stops.* Labor inhibits stomach motility, and this inhibition is usually complete.

A very positive attitude must be taken. If the patient cannot abstain completely, allow only clear fluids in sips. On admission to the hospital every obstetrical patient should be asked when she ate last, what she ate, and when labor began. The type of food is important in predicting the emptying time of the stomach. As indicated, the significant time interval is from eating to the onset of labor—*not* the time of delivery.

In spite of instructions and cooperation with them, a large number of obstetrical patients will approach delivery with stomachs that are not empty. Many patients will fall into labor at varying times in relation to food intake. The stomach may not be assumed to be empty unless 3 to 4 hours have elapsed to the onset of labor. A history of food intake within this period is a contraindication to general anesthesia.

At this point let us speak of two of these fundamental concepts to which I have referred. Do you know an "I always" doctor? —"I always use forceps."—"I always give a spinal."—"I always do an induction."—"I always have a general anesthesia for my patients."—Are you ever an "I always" doctor? *Do not fit the patient to the anesthesia.* Be familiar with as many agents and techniques as is feasible for your practice and physical setup, so that you may select the best in the circumstance.

Here is a second of these fundamental attitudes. *Do not use anesthesia all out of proportion in gravity and risk to the needs of the delivery itself.* How do you do this? Allow me to suggest the concept of "planned anesthesia" for your obstetrical patients. Recognizing that in the practice of obstetrics, and in anesthesia as well, one must be ready to meet situations as they arise; yet, having a well thought out plan of action as a foundation upon which to improvise will assure a better result. Where do you start? History-taking is of prime importance here, as in the practice of medicine generally. What is the patient's past experience with anesthesia? What is the parity of the patient? What was

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the size of previous infants? What are the possibilities of prematurity or immaturity or postmaturity? What previous episiotomies and forceps applications were done? These are only some of the points of useful information. The physical examination may include the status of the perineum, that is, scars and their condition, thickness of the perineal muscles, and the relative size of the introitus. Now, consider all the facts so obtained to determine what will be the planned minimal anesthesia requirements for each patient.

"Planned anesthesia" begins with a consideration of the safest procedure that will do the job. No one can deny that, under all circumstances, block anesthesia alters general physiology the least. Local infiltration is the simplest, and providing the accepted limits of total dose are followed, the safest. Pudendal block runs a close second on both counts, and in addition, is remarkably more effective and versatile. With the advent of lidocaine (xylocaine), local infiltration, and more especially pudendal block, are both successful in everyone's hands. Take the time and make the effort to become proficient with these two methods of anesthesia.

The term, "accepted limits of total dose of local anesthesia agents", was used. Let us define it. For procaine they are: 50 cc. of 2%; 100 cc. of 1%; or 200 cc. of ½%. Bear in mind, these figures represent the *maximum* and should be reserved for extensive block procedures in the *robust* individual. Lidocaine limits are one-half those of procaine. Lidocaine may be used in half the strength to accomplish the same intensity of block, and in addition, may be used in half the quantities due to the high diffusion factor of the drug. Therefore, properly used lidocaine is a less toxic, more effective drug than procaine.

What do you think is the commonest error in anesthesia for the obstetrical patient?—*It is this!* Allowing the patient to decide the kind and method of anesthesia. Seriously, do you allow your patient to decide whether she is to take chlorpromazine or phenobarbital, digitalis or quinidine? Certainly you do not. So, you are not going to do it in anesthesia either.

Know the safest use of each method and agent. For instance, there are few reasons to execute a spinal for delivery in anything but the sitting position. Why? Because it is easier. With the patient bending forward, the spinous processes spread to allow maximum room between the vertebra. There is probably no reason to use other than a heavy anesthetic solution. Why? Because the heavy solution, given in the sitting position, will fall caudad where you want its effect, and in addition, will prevent a high or total spinal. These are outstanding safeguards to the patient about which there is little or no choice. In using anesthetic blocking agents such as procaine and lidocaine, accepted limits of safe total dose and concentration have been established as described. Know them—and what's more—abide by them. Recently, there has been general recognition that so-called reactions and sensitivities to these and other block agents are in most cases an expression of overdosage, due either to an intravascular injection or to exceeding the accepted limits of total dose.

A cardinal principle of the practice of anesthesiology is that if you alter physiology, you must have the knowledge, the ability, and the equipment to compensate for the untoward results. In addition, continual observation is necessary to identify the presence and extent of these complications. Thus, in spinal anesthesia the most significant, unnecessary, and undesirable side effect is paralysis of the sympathetic nerves of the body segments affected by the anesthetic. In consequence two avenues of responsibility exist. The area of blockade should be held within the limits of usefulness and a vasopressor should be administered, prophylactically and therapeutically as needed. Now, unless blood pressure readings are taken at frequent intervals, in fact as often as every minute or two during the first ten minutes, whether or not the vasopressor is effective will be unknown. By sympathetic paralysis you have taken away the patient's ability to make normal homeostatic compensations and you must be certain at all times that the patient is kept safe. Do not be lulled by the 99 who are found to be safe and neglect to check the one hundredth.

Aspiration of vomitus is an outstanding hazard of general anesthesia in obstetrics. Even when the nothing-by-mouth dictum is strictly adhered to, provision must be at hand for Trendelenburg position on the obstetrical table, for suction, and for establishing an airway.

The next hazard of consequence during general anesthesia is hypoxia and anoxia. Care must be taken to supply at least 20% oxygen. Cyanosis must not be permitted. On the other hand lack of cyanosis does not guarantee adequate oxygenation. The administration of nitrous oxide is no excuse for providing less than 20% oxygen or tolerating cyanosis. Should respirations be depressed so that oxygenation is inadequate at the 20% level, or any other percentage, then the respirations must be manually assisted with concentrations of oxygen that will prove adequate. In general anesthesia, should a patient be doing poorly, as indicated for example by a continuing cyanosis that does not respond to corrective measures, discontinuation of the anesthesia is mandatory. It can later be resumed under more favorable conditions, or some form of local, nerve block; or regional anesthesia can be resorted to depending on circumstances. At the same time removal of carbon dioxide from the exhaled atmosphere must be provided for. This can be accomplished by adequate depth of respiration and by efficient carbon dioxide absorption in the anesthesia system. Retention of carbon dioxide by the patient often escapes notice and may result in a postdelivery hypotension that in the face of any other complication may compromise the patient unduly.

Unfortunately, anesthesia or relief of pain for surgery and obstetrics has been synonymous with unconsciousness or artificial sleep. With the ever increasing use of regional anesthesia, including infiltration, pudendal, epidural and spinal, professional thinking must change. A more informed public is rapidly learning that the conscious state may be a great advantage without sacrificing anything in the way of pain relief. Let us not be forced to accept the trend, but rather, let us do the pioneering and re-education of our patients.

100 Twelfth Street.

CHRISTMAS SEALS HELP BUY NEW MOBILE X-RAY UNIT

Tuberculosis . . . the No. 1 infectious killer . . today offers a challenge to all of us. Last year, 1,271 new cases of tuberculosis were reported in Wisconsin. Christmas Seals help control tuberculosis through research, education, case finding, social service and rehabilitation.

There are two great needs in the fight against tuberculosis today . . . find the unknown cases spreading the disease to those about them . . . research to discover a vaccine to prevent tuberculosis and better drugs for its treatment. The Wisconsin Anti-Tuberculosis Association is dedicated to help meet these needs.

To continue the WATA's search for unknown cases, it is necessary to buy a new mobile X-ray unit. Over the past ten years, nearly a half million people in Wisconsin have stepped through the doors of the present unit. It is now old and worn, with equipment which is becoming outdated. This unit is being purchased with the confident hope that the people of Wisconsin will contribute generously during this year's 50th anniversary Christmas Seal campaign.—*Wisconsin Anti-Tuberculosis Association.*

Clinicopathologic Conference

Sponsored by the Section on Pathology, State Medical Society of Wisconsin
Guest Editor: James W. Erchul, M. D.

A CASE PRESENTATION*

ON MARCH 19, 1957, a 55-year-old white male carpenter was admitted to the hospital with a presenting complaint that several hours previously severe abdominal pain with nausea, vomiting, and gradual abdominal distention had developed. It was learned that he had had periodic bloating for 15 to 20 years. This had been most severe over the past 7 years and apparently became more pronounced when the patient was under stress. During "recent weeks" his weight had fallen from 171 pounds to 143 pounds. A review of the systems revealed that there had been no dyspnea, chest pain, or chronic cough. The appetite had been good prior to this admission. The bowels moved regularly and there had been no rectal bleeding. No urinary symptoms were discovered. In 1933 a malignant left testicular tumor had been removed and the surgery was followed by x-ray therapy.

On physical examination the blood pressure was 130/92 and the temperature was normal. The patient appeared to be in very severe pain. The general examination was negative except for the diffuse abdominal tenderness with distention. The working diagnosis was partial bowel obstruction.

A chest x-ray and gallbladder study were within normal limits. A flat plate of the abdomen revealed a dilated loop of small intestine in the epigastric region, the mucosal pattern of which suggested jejunum. There was a suggestion of free fluid within the abdomen and the pattern of barium throughout the small intestine indicated small bowel dysfunction. The esophagus and stomach were essentially negative. A barium enema was likewise within normal limits. The hemoglobin was 14.2 gm.% and there were 15,000 white blood cells per cu. mm. with 70% neutrophils, 3% stab forms, 1% eosinophils, 19% lymphocytes, and 7% monocytes. The urine examination was negative. The serum cholesterol was 155 mg.%. A fasting blood sugar was 114 mg.% and the glucose tolerance curve displayed a flat low configuration with the maximum 2-hour level being 134 mg.%. An icterus index was 6.7 units. The nonprotein nitrogen was 23 mg.% and the V.D.R.L. was negative. An electrocardiogram was not remarkable except for low voltage. The patient's temperature remained normal throughout hospitalization and vomiting did not occur. The patient was greatly improved shortly after admission and was discharged after 4 days.

Second Hospital Admission

The patient returned to the hospital on April 7, 1957. His principal complaint was marked gaseous distention of the abdomen with severe nausea of several hours duration. The temperature was normal and the blood pressure was 114/74 with a pulse of 60, which was regular. Again the principal findings were restricted to the abdomen. A distended loop of bowel on the left side of the abdomen was visualized. Percussion over this area caused it to become tonic and dilated. Ascitic fluid also appeared to be present. A sigmoidoscopic examination revealed no abnormality and the prostrate gland was not enlarged. The admission hemoglobin was 14.2 gm.% and the white blood cell count was 6,600 per cu. mm. with 71% neutrophils, 1% stab forms, 25% lymphocytes, and 3% monocytes. The urinalysis was negative. The marked gaseous distention of the abdomen was resolved promptly with application of heat to the abdominal wall and an enema. He was discharged 4 days after admission.

Final Hospital Admission

Following a heavy supper at approximately 6:00 o'clock on May 31, 1957, a sudden pain in the abdomen developed, which was more severe than any previous episode the patient had experienced. His wife administered an enema, which failed to relieve the pain. The

* From St. Elizabeth Hospital, Appleton, Wisconsin.

patient at first refused hospitalization. Two separate doses of meperidine hydrochloride were ineffective, and the patient was hospitalized 5 hours after onset. On admission he appeared slightly cyanotic and had severe nausea and abdominal pain. The blood pressure was 114/74, the temperature was 97.8 F., and the pulse was 108. On physical examination there was generalized spasm and board-like rigidity over the abdomen with some distention. Peristalsis was almost completely absent and there was a suggestion of abdominal fluid present.

An emergency admission flat plate of the abdomen revealed air under the diaphragm with air and fluid levels in the bowel. The hemoglobin was 15 gm.%, and there were 2,500 white blood cells per cu. mm., with 36% neutrophils, 22% stab forms, 40% lymphocytes, and 2% monocytes. A blood amylase determination was within normal limits. The patient was taken to the operating room, but surgery was not performed because of the appearance of severe intractable shock, which failed to respond to fluids, oxygen, and blood. Death occurred on the following morning at 10:00 o'clock.

Dr. Ralph O. Kennedy: X-rays of the chest, a cholecystogram, and a barium enema performed at the first admission were essentially normal. The supine and upright films of the abdomen showed a dilated loop of bowel in the left upper quadrant with fluid levels present. The distended loop had the appearance of small bowel, most probably jejunum. A small amount of gas was scattered in the colon and the remaining portion of the small bowel. The appearance suggested an obstruction of the upper small bowel, the cause of which could not definitely be determined.

Several films of the abdomen taken on the final admission showed multiple loops of small and large bowel dilated with gas and fluid. The stomach was dilated with similar content. Free peritoneal air was present. The appearance was that of a perforated viscus with associated paralytic ileus. The site of the performation could not be determined.

Discussion

Dr. William W. Chandler: In essence we have a 55-year-old male with a vague history of intermittent abdominal bloating for years. He then lost 28 pounds in a few weeks, and had sudden onset of symptoms of small bowel obstruction, intermittent pain, and vomiting, which were temporarily relieved by nonoperative measures, recurred, and subsequently resulted in perforation of a viscus with shock and death. Additional information regarding the nature of the pain, whether it was intermittent or continuous, and also the nature of the bowel sounds, whether they were hyper- or hypoactive, and whether rushes were present, would have been of value. In addition examination of the stool for occult blood would have diagnostic importance in this case.

In view of the very severe intermittent pain and the x-ray picture of a solitary markedly dilated loop of jejunum in the epigastric area and the normal temperature, a paralytic type of ileus would be improbable. This is more likely a mechanical type of intestinal obstruction and focuses our thinking on the various mechanisms of obstruction of the intestine. There are three types of mechanical obstruction: (1) intraluminal occlusion, (2) intramural obstruction, and (3) extraluminal occlusion. The first group would include tumors, polyps, and foreign bodies, *e.g.* gallstones. The intramural obstruction type would include infiltrating type of tumors as well as inflammatory bowel lesions such as regional enteritis, ulcerative colitis, or tuberculosis. The extraluminal type of bowel obstruction, which accounts for at least 90% to 95% of small bowel obstructions, is caused by adhesive bands in 70% of the cases. Incarcerated hernias make up the majority of the remainder, with volvulus and congenital abnormalities contributing a small percentage. The extraluminal type, of course, also accounts for the majority of the complications of strangulation or closed-loop obstruction.

The differential diagnosis of small bowel obstruction would therefore include the above mentioned three mechanisms of bowel obstruction. With this in mind one of the following specific conditions may have caused the patient's death.

1. *Hernia or Volvulus*—Percentagewise the most likely cause would be some type of extraluminal obstruction, especially hernia. There was no evidence of external hernia, and there was no evidence of internal hernia, which would be identified by a persistent closed-loop type of obstruction. There was no evi-

dence radiologically of volvulus. These facts, along with the intermittency of the obstruction, are against this diagnosis.

2. *Adhesive Bands*—Less common in the absence of previous surgical incisions, the possibility of bands caused by irradiation 24 years prior to the patient's death must be considered. However, it must be assumed that this treatment would have been focused on the lower abdomen to eradicate lymphatic spread of the testicular malignancy, which would be some distance from the evident jejunal area of obstruction. Again, intermittency is not a dominate characteristic of such an obstruction.

3. *Congenital Abnormalities*—These can essentially be eliminated by the normal position of the bowel as seen on x-ray, as well as by the age of the patient.

4. *Inflammatory Lesions*—A febrile course would have been expected with a greater tendency to chronicity. While regional enteritis may occur occasionally in the jejunum or duodenum, the sudden occurrence of a primary solitary jejunal lesion would be difficult to imagine and perforation even more uncommon. The lack of bowel habit change, bleeding, and mucus also rule against ulcerative colitis.

5. *Foreign Body*—This is considered for completeness. There was no evidence of foreign body by x-ray, no history of ingestion, and no evidence of gallbladder disease.

6. *Tumors*—Small bowel tumors are very rare. Approximately four-fifths of them are benign lesions, mostly lipomas, leiomyomas, and adenomas. The malignant varieties constitute only about 0.5% of the total malignancies of the gastrointestinal tract. Consideration of metastatic tumor from the testicle is unlikely in this case because of the 24-year interval and the absence of a primary tumor.

   In this case a benign small bowel tumor could account for the intermittent obstruction and the intestinal dysfunction but not for the perforation and weight loss. Therefore we come to the percentagewise least likely diagnosis, but in this case I believe the most likely diagnosis, a malignant small bowel lesion. The weight loss, the intermittency of the obstruction, probably representing edema and inflammation, the evidence of intestinal dysfunction, the terminal episode of perforation without other evidence of likely causes of perforation such as peptic ulcer, all point to such a lesion. Therefore my diagnosis is carcinoma of the jejunum.

This case does illustrate two of the dangers of non-operative control of bowel obstruction: the possibility of the future occurrence of a perforation, or the presence of malignancy. In cases of small bowel obstruction of undetermined cause, even after satisfactory decompression medically, exploration is often indicated for diagnostic as well as therapeutic purposes. One other point is that occasionally with an upper gastrointestinal tract perforation, the shock picture, due to continual outpouring of intestinal contents with the resultant peritonitis, becomes progressively more intractable despite all antishock measures. In such a case surgical closure of the perforation in the face of profound shock may be necessary to preserve life.

Autopsy Findings

Dr. James W. Erchul: The body was that of a 55-year-old white male measuring 67 inches in length and weighing an estimated 150 pounds. External examination was not remarkable except for the presence of a well-healed scar over the left superior aspect of the scrotum and the absence of the left testicle. The most significant pathologic findings were found within the abdomen. It contained 1,500 ml. of an amber fluid. There was gross contamination of the peritoneum by numerous recognizable food particles, including large pieces of watermelon together with seeds and rind, pineapple in large chunks, and portions of cucumber indicating that an enormous quantity of food must have been consumed. The small intestine was dilated approximately three times the usual size and a fibrinous peritonitis was evident. The stomach was greatly distended and contained 250 ml. of food material similar to that found in the peritoneum. Sixty-three centimeters beyond the ligament of Treitz on the antemesenteric border of the jejunum there was an oval perforation having a sharply punched-out appearance measuring

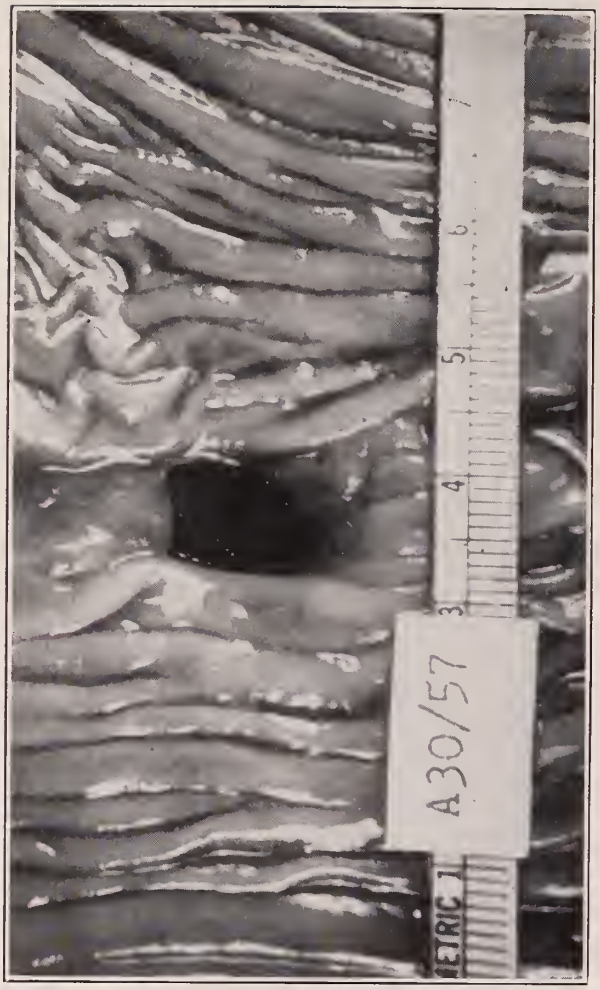

Fig. 1—Perforated primary adenocarcinoma of jejunum. Note nodular appearance of mucosa at margin of perforation.

1.2 by 1.1 cm. diameter (fig. 1). Fibrinous material was present over the serosa and here and there was some puckering of the serosa at this point. The transverse mucosal folds were edematous and at either lateral margin of the ulcer the tissues were slightly indurated having a pale gray appearance. Microscopic sections of the margins of the perforation revealed an adenocarcinoma which had invaded the muscularis layer.

Other findings of importance included a bilateral aspiration pneumonitis of recent origin. This was most evident in the right lower lobe. The heart was not remarkable except for slight interstitial myocardial fibrosis of the left ventricle. The liver was slightly increased in weight and displayed parenchymatous degeneration. The gallbladder contained three soft mucosal papillomas measuring up to 0.5 cm. in diameter. The spleen and kidneys were not remarkable. Within lymphatic spaces of the medullary portion of one adrenal gland, several small clusters of tumor cells were found. Examination of the scrotum revealed no evidence of tumor and no tumor was evident in abdominal lymph nodes.

In correlating the case history with the autopsy findings it appears evident that the patient's symptomatology over the previous 3 months may be attributed to a malignancy of the small intestine. The difficulties of examining this portion of the gastrointestinal tract by x-ray are well known and the only clue was the dilated loop of bowel. On the evening of May 31, shortly after eating supper, which must have been enormous judging from the large amount of material found at autopsy, the patient's symptoms became greatly accentuated. Perforation of the primary carcinoma of the jejunum must have occurred at this time. From then on his condition rapidly deteriorated due to spreading peritonitis and resultant shock until death occurred the following morning. We were unable to review microscopic sections of the testicular tumor removed in 1933. However, the adenocarcinoma of the jejunum was quite typically of gastrointestinal origin in its structure and in no way resembled a testicular malignancy.

THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

The twenty-second annual meeting of The New Orleans Graduate Medical Assembly will be held March 2, 3, 4 and 5, 1959, with headquarters at the Roosevelt Hotel, New Orleans, Louisiana. Details of the meeting and the clinical tour to Latin American cities are available at the office of the Assembly, Room 103, 1430 Tulane Avenue, New Orleans 12, Louisiana.

Lung Cancer

As It Looks to Your State Board of Health

Cancer of the lung is a medical and public health problem of considerable size. In Wisconsin it is the most common cause of cancer deaths in males and is now approaching 600 yearly deaths for both sexes. A review of lung cancer death rates in Wisconsin during recent years shows sustained and marked increases. (Table 1). In 1930 there were 91 deaths for a rate of 3.1 per 100,000 population. In the most recent year, 1957, there were 571 deaths for a rate of 15.0. This problem is adversely complicated, first by the location of the lesion and the crudeness of case finding and diagnostic procedures so that early diagnosis is usually precluded, and second by unsatisfactory curative means. The 5-year survival rate in cases diagnosed and reported to the board of health in 1948 was 4.9 per cent.

TABLE 1—NUMBER AND RATE OF LUNG CANCER DEATHS IN WISCONSIN

Year	*Number of deaths*	*Rate per 100,000 population*
1930	91	3.1
1935	137	4.5
1940	148	4.7
1945	204	6.2
1950	358	10.4
1955	515	13.9
1957	571	15.0

The prevention of lung cancer appears to hold the most promise for better control, pending major discoveries in chemotherapy or possibly in early case-finding tests. In recent years cigarette smoking has been indicated as probably the most important cause of lung cancer. Some 16 separate studies, employing different approaches and in different geographical areas, have produced the same statistical observation—that there is an association between smoking and the number of lung cancers occurring in the population being observed. Apparently, there are no acceptable studies in the medical literature which show no relationship between cigarette smoking and lung cancer. Pathological studies also show that the incidence of tracheobronchial epithelial changes varying from hyperplasia to carcinoma *in situ* have a direct relationship to cigarette smoking. Both the profession and the public have long acquaintance with the chronic bronchitis or cigarette cough due to excessive smoking.

The studies of Hammond and Horn tend to confirm the accepted fact that lung cancer is more frequent in urban than in rural populations and that carcinogenic agents probably occur in the polluted air of cities. However, their findings also show that the rate of lung cancer occurrence in rural smokers approaches the rate in urban smokers, thus indicating that between the factors of smoking versus urban air pollution, smoking is of far more importance. The indicated risk of non-smokers developing epidermoid lung cancer at some time in their life is 1:270, while the risk for persons smoking 2 or more packets of cigarettes a day is 1:10. The main objections to the indictment of cigarette smoking as an important cause of lung cancer have come from the Tobacco Industry Research Committee.

In July 1957, after review of evidence and the presentation of conclusions thereon by the scientific Study Group, the Surgeon General of the Public Health Service issued a statement to medical and public health authorities in which he stated, "The Public Health Service feels the weight of evidence is increasingly pointing in one direction: that excessive smoking is one of the causative factors in lung cancer." In recent reports the British Medical Research Council has issued similar warnings.

In the light of the inadequacy of early case finding procedures for lung cancer and the tremendous increase in the death rate, it would appear timely and prudent for the public and profession to weigh carefully the mounting evidence that excessive smoking is one of the causative factors in lung cancer.
—A. L. Van Duser, M. D., M. P. H., *Director, Division of Cancer Control.*

Minutes of Council Meeting, Madison March 1–2, 1958

1. Call to Order and Roll Call

In the absence of Chairman Arveson, the Council was called to order by Secretary Crownhart at 2:05 p.m. on Saturday, March 1, at Society headquarters in Madison.

Councilors present were Doctors Lokvam, Houghton, Dessloch, Heidner, Fox, Bell, Garrison, Ekblad, Bernhart, Conley, Conway, Galasinski, Kilkenny, Leahy, and Past-president Simenstad; Doctor Hill present Saturday only and Doctor James present Sunday.

Officers and guests present were Doctors Kasten, president; Fons, president-elect; Hildebrand, speaker of the House of Delegates; Griffith and Stovall (Saturday), delegates to the American Medical Association; Tormey, secretary of the State Board of Medical Examiners (Saturday).

Staff and consultants present: Messrs. Crownhart, Thayer, Ragatz, Koenig; Misses McGruer and Pyre; Messrs. Tiffany, consulting actuary; Gill and White, certified public accountants; Gavin and Murphy, legal counsel; Messrs. Hoops and DuBois of the accounting staff present on Sunday.

2. Appointment of Acting Chairman

On motion of Doctor Ekblad, seconded and carried, Doctor Bernhart was appointed acting chairman.

3. Approval of Minutes

On motion of Doctors Garrison–Dessloch, carried, minutes of the February, May, July, and September 1957 Council meetings, as published in THE WISCONSIN MEDICAL JOURNAL, were approved with a correction in the May 9 minutes that Doctor Galasinski voted in the negative on the motion, passed at that meeting, which extended authority to the Commission on Medical Care Plans to deal with the subject of the agency relationship with Blue Cross as it sees fit.

4. Introduction of New Business

Doctor Ekblad asked that study be given to the practice followed in some states of having a society committee review liability cases and advise physicians on the course to be followed in a suit. The matter was referred to legal counsel for study and later report to the Council.

5. Journal Advertising Policy

Since 1937 it had been the policy of the Journal not to carry advertising of collection, credit, or similar organizations, even though such organizations held their operation exclusively to the medical and dental professions and hospitals, and seemed accepted in the areas in which they operated. In the fall of 1957, such an organization applied for advertising opportunities and the local county medical society approved it for advertising in the Journal. This approval was sought after a mail ballot of the Executive and Scientific Committees of the Council, which endorsed the procedure of securing county society approval of such organizations desiring Journal advertising space.

On motion of Doctors Hill–Simenstad, carried, the Council accepted this procedure as a future Journal advertising policy.

6. Medicare

The Council had been supplied with detailed reports of negotiations to date by the Commission on Medical Care Plans, the staff and consultants, on a new Medicare contract for 1958. These reports had been reviewed with the Executive Committee at its meeting just preceding the Council meeting, and there was further discussion and questions by the Council.

Doctor Dessloch said the Commission and its committees hoped the Council would approve negotiations to date, and approve the general policy that all contracts with the federal government should pertain to administrative matters, while professional management of such contracts in the matter of payment for services within the maximum of the negotiated schedule of allowances should be left to physicians.

On motion of Doctors Galasinski–Simenstad, carried, the Council approved the work thus far done and extended a vote of appreciation to the Commission in its efforts to maintain the philosophy of payment for services rendered.

7. Commission on State Departments

a. Recommendations Concerning Highway Safety

The Executive Committee which had studied the several recommendations of the Division on Safe Transportation relating to driver education programs, first aid training, and operation of ambulances, recommended that action upon them be laid over to the May meeting in the belief that some of them needed further study as to financial and legislative implications.

On motion of Doctors Garrison–Hill, carried, the recommendation of the Executive Committee was approved.

b. Board of Health Pilot Project in Geriatrics

The State Board of Health had reviewed with the Commission on State Departments its proposal for utilizing $62,000 in federal funds for a pilot project in the restoration of bedridden aged in nursing homes to some degree of self care. The program would be centered in a single county with approval of the local county medical society, and the Board would

employ a "physical therapy team" consisting of a nurse, physiotherapist, social worker, and health educator to establish a restorative program among elderly persons housed in nursing homes. These people would be referred to their family physicians for evaluations and recommendation as to the type of therapy which might be instituted to get them out of bed or back into society. Physicians would be reimbursed by the Board for these examinations and other consultative services, but this program would not provide payment for surgery or medical treatment unrelated to the restorative effort. It is expected that when the pilot project is concluded, local sources will take over financing and continuation of the program.

The Commission on State Departments recommended that the Society endorse the project on the following conditions, that

(1) county medical society approval be a prerequisite to establishment of the project.
(2) the Board carefully explain the type of "medical care" which is provided as part of the program through Board funds.
(3) there be additional careful study of how such a program will be handled when the Board of Health funds are no longer available.
(4) the project be limited to a pilot study with a definite cut-off date and re-evaluation before continuing in other areas.
(5) the Division on Geriatrics offer its services in an advisory capacity to the Board to plan development of the project and evaluate its effectiveness.

The Scientific Committee recommended that the Commission's report be accepted, but Doctor Bell emphasized that the proposed project of the Board of Health did not contemplate its assuming the role of providing direct treatment and rehabilitation.

Doctor Kilkenny and other councilors, while favoring this limited project, expressed the opinion that total problems in the geriatric field were important ones and the long-range program of the profession should be to keep older people productive and out of nursing homes.

On motion of Doctors Dessloch–Galasinski, carried, the report was accepted.

c. Fund Raising for Health Causes

A county medical society had requested advice with respect to the appropriate disposition of local agency monies collected for specific health causes, such as cancer, heart, or poliomyelitis, in campaigns not affiliated with the corresponding voluntary health agencies, should they be turned over to the county society.

The Executive Committee had discussed the matter and believed it involved a matter of policy which the Society's Foundation should consider.

On motion of Doctors Simenstad–Hill, carried, the matter was referred to the Foundation.

8. Statement on Ethical Principles

On motion of Doctors Fox–Conway, carried, the Council adopted the following statement, to be reported to county medical societies through the Councilors and Officers Newsletter with the request that county secretaries note and forward this action to the appropriate committee:

"A problem which is frequently presented to the Secretary's office, or to a committee, involves the practice in some areas of indicating ancillary personnel associated in a physician's practice. In some instances such ancillary personnel, engaging in a limited practice and on a 'free lance' basis, establish their own office but share certain facilities, such as a waiting room, with a physician and surgeon. 'Ancillary personnel' includes those engaged in the fields of podiatry (chiropody), physical therapy, in some cases optometry, clinical psychology, and others. As used in this statement, 'ancillary personnel' does not refer to the practice of dentistry.

"The Council of the State Medical Society of Wisconsin has not recorded formal action upon these inquiries in the past, but has known of informal advice that the *employment* of such individuals by physicians, and for the purpose of utilizing their training under physician direction for patient care, is not unethical.

"But physicians have been advised that designation of these individuals on letterheads, on professional announcements, or in the physician's office itself, is improper.

"Such practice has been felt objectionable on the basis that it may well create in the minds of the patient that these individuals are of training comparable to that of the medical profession and have achieved a professional equivalency. It is further objectionable in that publicizing such affiliation tends to at least indirectly constitute a 'puffing' of the physician's facilities in comparison to those of others who do not have such facilities or services in their immediate practice.

"It follows, then, that where there is no employment involved the sharing of a common waiting room, or in some other manner publicly associating one of limited skills with a physician and surgeon, are also improper. This constitutes an indirect violation of the same principle enunciated in the case of employed ancillary personnel."

9. Committee on Coordination of Medical Services

The Secretary supplemented material distributed to the Council reporting on the series of meetings of this committee with University of Wisconsin officials and medical school representatives, attempting to find solutions to the problems of medical education

caused by the lack of sufficient clinical material for teaching purposes—at the present most acutely felt in the obstetric department. Proposals and counter-proposals had been made, and further meetings would be held on the matter. He called upon the Council to lend its support to the committee in finding the ultimate solution to the needs of medical education and showing practicing physicians their responsibility in the matter.

On motion of Doctors Simenstad–Galasinski, carried, the report was accepted and referred to the Scientific Committee with the suggestion that it meet with the committee and University representatives.

10. Elections

a. Chairman of the Council

Dr. R. G. Arveson was nominated by Doctors Dessloch–Garrison, and Dr. E. L. Bernhart was nominated by Doctors Conway-Kilkenny; Doctor Arveson re-elected by ballot vote.

b. Treasurer of the Society

On motion of Doctors Dessloch–Garrison, Dr. F. L. Weston was elected to succeed himself as treasurer.

c. Assistant Treasurers of the Society

On motion of Doctors Conway–Fox, and Doctors Dessloch–Galasinski, respectively, Doctors H. Kent Tenney and Nels A. Hill were elected to succeed themselves as assistant treasurers.

d. Secretary of the Society and of the Council

On motion of Doctors Dessloch–Bell, Mr. C. H. Crownhart was re-elected for the ensuing year.

e. Editorial Director of THE WISCONSIN MEDICAL JOURNAL

On motion of Doctors Conway–Fox, Dr. J. M. Sullivan was re-elected for a one-year term.

f. Medical Editor of THE WISCONSIN MEDICAL JOURNAL

On motion of Doctors Galasinski–Hill, Dr. R. S. Baldwin was re-elected for a two-year term.

11. Annual Meeting

With approval of the House of Delegates in 1957, efforts had been made to schedule the annual meeting of the Society in the Fall of the year. It appears that there is no possibility of securing auditorium space until 1960 or 1961; and another major conflict, the Fall meeting of the Wisconsin Academy of General Practice, had been discussed with its president, Doctor Nereim, by the Scientific Committee. Doctor Bell reported that the Academy would retain its September meeting date, and asked the Council if it wished the staff to attempt to schedule the Society meeting the last half of October at the earliest possible time, and as far removed as possible from the Academy meeting.

On motion of Doctor Ekblad, seconded and carried, the Council so ordered.

Pursuant to Council action last July when it met with the Council on Scientific Work, the annual dinner in 1958 is scheduled for Wednesday night instead of Thursday. This necessitates a change in the schedule of House of Delegates sessions, and the Council accepted the Executive Committee recommendation that they be held Monday night, with reference committees meeting during the day on Tuesday, the second session Tuesday night, and the third Wednesday morning.

12. Exchange of Meeting Privileges with Doctors of Dental Surgery

On motion of Doctors Bell–Fox, carried, the Council established the following exchange policy with the Wisconsin State Dental Society:

a. Publication in each organization's Journal of an invitation to members to attend the other's Annual Meeting.

b. Registration and admittance of members upon presentation of their current membership card.

13. Bylaw Amendments

Doctor Fox proposed for discussion the desirability of creating the position of vice-chairman of the Council, to be filled by election of the Council.

Discussion and review of the bylaws followed.

On motion of Doctors Fox–Ekblad, carried, the Secretary was requested to prepare an appropriate resolution for House action, clarifying the bylaws as to officers of the Council and permitting the election of a vice-chairman.

The Secretary then asked Council approval for requesting House action to amend the bylaw which refers to the first meeting of the Council "in January of" each year. The amendment would delete the quoted phrase.

On motion of Doctor Ekblad, variously seconded and carried, such amendment was approved.

14. Council on Scientific Work

At the July 1957 Council meeting, the Council on Scientific Work had been authorized to develop, on a pilot study basis, and as a variation of the postgraduate education programs of the Society, plans for hospital staff teaching services. The Scientific Committee of the Council had reviewed the proposal subsequently developed by the Council on Scientific Work, and recommended that the Council approve institution of the service on a quarterly basis starting in 1958, if possible, and continuing through the academic year. Tentative plans were for the University of Wisconsin to serve the hospitals in Wausau, and Marquette to serve the hospital in Fond du Lac or hospitals in Sheboygan. Reimbursement of speakers for this pilot series, at the rate of $100 including travel, would be made by the Foundation from an initial grant by the Society, amounting to $200 in 1958 and $600 in 1959. If the service proves

successful and the Council approves its expansion on a statewide basis, those hospital staffs requesting the service would assume the cost; except that a modified program would be set up for smaller hospitals with partial financing out of funds secured by the Foundation for this project.

On motion of Doctors Dessloch–Houghton, carried, plans for a pilot series of hospital staff teaching services were approved.

The Council on Scientific Work also proposed to revise the format somewhat of the traditional circuit teaching programs in 1958–59 by scheduling single day and two-day circuit meetings on Wednesdays and Thursdays when the greatest attendance is experienced. The program would be concentrated in the afternoon, including a question and answer period; and dinner would not be planned as an integral part of the clinic. It was recommended also that the registration fee be established at $5.00.

On motion of Doctors Bell–Kilkenny, carried, this proposal was approved.

A third proposal was that the State Medical Society serve as a clearing house to coordinate information on postgraduate education in the state, and publish a quarterly bulletin of meetings scheduled, including the universities and allied health organizations, to be circulated to county medical societies and those organizations concerned.

On motion of Doctors Galasinski–Simenstad, carried, the publication of such a calendar, and also in THE WISCONSIN MEDICAL JOURNAL, was approved.

The Council recessed until Sunday morning, March 2.

15. Wisconsin Physicians Service

There was a report by the Secretary, followed by a period of discussion, on operations of WPS since the agency contract with Blue Cross came to automatic termination. No action was taken.

16. 1958 Budget

The Finance Committee recommended a total budget for the State Medical Society of $316,298. Society income from dues and other sources was estimated at $339,570. The Council reviewed each budgeted account and approved the operating budget as presented at $174,805; staff travel expense at $13,155; and in executive session approved some salary adjustments which increased the payroll budget to $134,993 and the total to $322,953.

The following executive salaries were approved by the Council:

C. H. Crownhart, Secretary	$30,000
Earl R. Thayer, Assistant Secretary	16,000
Roy T. Ragatz, Assistant Secretary (part-time)	5,250

17. Bylaw Amendment

Doctor Hildebrand, Speaker, proposed that the Council recommend a bylaw amendment in Chapter III, Section 2, providing that county societies notify the State Society of elected delegates by the end of the calendar year preceding House sessions in which they are to serve.

On motion of Doctors Conway–Ekblad, carried, this recommendation was accepted.

18. Adjournment

The 1958 annual meeting of the Council was adjourned at 1:30 p.m.

C. H. CROWNHART,
Secretary.

Approved:
E. L. BERNHART, M.D.,
Acting Chairman of the Council

Minutes of Council Meeting, Milwaukee May 4–6, 1958

1. Call to Order and Roll Call

The Council was called to order by Chairman Arveson at 1:50 p.m. on Sunday, May 4, 1958, at the Hotel Schroeder in Milwaukee.

Following is the attendance record for the Council sessions on May 4 and 5. The Council met again Tuesday noon to complete its business; and the roll call was dispensed with, a quorum having been determined as present.

Councilors: Doctors James, Lokvam (Sunday), Hill, Houghton, Dessloch, Heidner, Carlson (Sunday), Fox, Bell, Garrison, Arveson, Ekblad, Bernhart, Conway, Galasinski (Sunday), Kilkenny (Sunday), Leahy, and Past-president Simenstad.

Officers and others: Doctors Kasten, president; Fons, president-elect (Sunday); Hildebrand, speaker of the House (Sunday); Hirsch, vice-speaker; Weston, treasurer; Witte, Griffith and Stovall, A.M.A. delegates; members of the Commission on Medical Care Plans present Sunday and at various other times: Doctors Krohn, Mason, Foregger, Aageson, Casper, Supernaw, Finn, Goldstein, Reznichek, Davis, and Wolf; guests present Sunday: Doctors Baldwin, medical editor of THE WISCONSIN MEDICAL JOURNAL; Quisling, chairman, Committee on Public Policy; Sorenson and Gearhart, reference committee chairmen; Neupert, state health officer; Mr. Hedback representing the American Medical Education Foun-

dation; guests present Monday: Doctors Picard, Superior, and McCann, La Crosse.

Staff and consultants: Messrs. Crownhart, Thayer, Ragatz (Sunday), Doran, Doege, Koenig; Misses McGruer and Pyre; Messrs. Tiffany, consulting actuary; Gill and White, certified public accountants; Murphy, and Gavin (Sunday), legal counsel.

2. Report of Executive Committee

Mr. Crownhart reported to the Council for its information and later action several matters considered by the Executive Committee that morning:

a. Lay-operated laboratories

The committee was advised of an informal memorandum from the attorney general's office to the effect that such laboratories may not be in violation of the medical practice act since they are not treating patients. Because of the implications in this tentative opinion, the committee referred the subject to the Committee on Public Policy together with several related matters, including the Council's statement on employment of ancillary personnel, with the request that the committee meet with those groups concerned in these matters and subsequently report back to the Council.

b. Section delegates

The Executive Committee approved the Secretary's advice to a specialty society that section delegates to the House of Delegates of the State Medical Society must be elected by a particular specialty group acting as a section of the State Society and not as a separate organization or corporation.

c. Economic Institute

The committee approved establishment on a trial basis of an economic institute to be held in Madison late in 1958–59. Total attendance would be limited and a registration fee charged. Suggested topics include estate planning and business management information. If the trial institute proves successful, consideration would then be given to conducting them around the state.

d. Resolution on group practice

The committee recommended that the Society affirm and make applicable in Wisconsin the following resolution adopted by the American Medical Association which provides an ethical means for taking advantage of pension plan tax saving devices:

"Whereas, it has been found by experience that physicians practicing as a partnership, association or as members of other lawful group arrangements can preserve the physician-patient relationship, insuring that medical responsibility lies in the hands of the patient's own doctor and not in the hands of an unlicensed person or entity; and

"Whereas, the ethical principles of the AMA apply to the individual physician whether he practices alone or with a group; now therefore be it

"Resolved, that the House of Delegates affirm that it is within the limits of ethical propriety for physicians to join together as partnerships, associations or other lawful groups provided that the ownership and management of the affairs thereof remain in the hands of licensed physicians."

e. Institute on Athletic Injuries

The Executive Committee approved handling this institute, to be held in November, through mechanisms of the Foundation so that contributions anticipated from interested outside sources may be tax-exempt.

3. Committee on Public Policy

Dr. A. A. Quisling, chairman, cited the need for closer personal contact with patients and legislators on matters of public health interest both between and during sessions of the Wisconsin Legislature. He said the Committee would call upon councilors and officers, delegates and alternates, county presidents and secretaries, local legislative committees, and the Woman's Auxiliary, to assist it in carrying forth an effective legislative program. He reported that working with the Society staff, the Committee hoped to improve the channels of communication through legislative bulletins.

Doctor Conway also urged the Council to use its influence in securing interest and support in legislative matters. Doctor Simenstad suggested that volunteer physicians be scheduled to attend each day of the legislative session.

4. Wisconsin Medical Journal

Dr. R. S. Baldwin, medical editor, reported on meetings between the editorial board and the staff looking to improvement of the Journal as to content, layout, and financial condition. He said they were jointly working on a manual outlining standard procedures for all phases of Journal publication. It was anticipated this project would suggest some changes, which will be presented to the Scientific Committee and to the Council itself.

On motion of Doctors Galasinski–Carlson, carried, the report was accepted and a subsequent report requested as to proposed changes.

Mr. Thayer asked for immediate action of the Council on advertising rates. He said the State Medical Journal Advertising Bureau, through which a number of state medical journals, including Wisconsin, secure much of their advertising, had suggested an across-the-board increase in advertising rates of about 5 per cent.

On motion of Doctors Garrison–Hill, carried, this increase in rates was approved.

On motion of Doctor Conway, variously seconded and carried, the Council thanked Doctor Baldwin for his excellent work on the Journal.

5. **American Medical Education Foundation**

Doctor Heidner reviewed what Wisconsin physicians have done by way of contributions to this Foundation over the years of its existence and expressed the hope that through education as to its purposes and the means of contributing, there could be an improvement in this regard, despite the "competition" for funds by the Society's Foundation, including the Student Loan Fund.

He introduced Mr. John Hedback, executive secretary of AMEF, who spoke briefly to the Council and, at Doctor Heidner's request, was asked to speak to the House of Delegates at its Tuesday night session.

Mr. Crownhart suggested that there be placed on the agenda of the trustees of the Charitable, Educational and Scientific Foundation at its annual meeting to be held that week, the creation of a committee within the Foundation with specific responsibility in activities relating to the American Medical Education Foundation.

On motion of Doctors Dessloch–Garrison, carried, this suggestion was accepted.

6. **Joint Meeting with Commission on Medical Care Plans**

a. Review of resolutions and developments pertaining to the operations of Blue Shield

Secretary Crownhart reported to the Council at length on his and others' trips around the state speaking at county and district meetings, and what he considered would be the issues coming before the House of Delegates, particularly with reference to Wisconsin Physicians Service, and including the resolution by Milwaukee County delegates calling for a study of the State Medical Society. A long period of discussion followed.

At the time of dinner recess, Chairman Arveson appointed a committee composed of Doctors Bell, Hill, Dessloch, Fox, Kilkenny, and Bernhart, to bring back to the Council a statement upon which it might act.

Following recess, Doctor Bernhart reported, as he had to the committee, that he had been given the opportunity to see the material that Milwaukee County would introduce in support of its resolution. He reported some of the questions contained in it with reference to the Society secretary, staff, consultants, and the Council. He said that it did not refer to the "split" between Blue Cross and WPS. The committee urged all councilors to attend the reference committee meeting in support of their past actions and what they propose to do in the future.

On motion of Doctors Ekblad–Leahy, carried, the report was accepted and the councilors were directed to attend the reference committee meeting.

The subject was discussed again on Tuesday after the supporting data to the Milwaukee resolution had been released, but no action was taken by the Council except general agreement with the Secretary's proposal that the constitution and bylaws of all county medical societies should be analyzed in the near future as to their compliance with those of the State Medical Society.

Doctor Casper, member of the Commission on Medical Care Plans read to the Council the following resolution adopted by the Commission Sunday morning, Chairman Dessloch abstaining:

"Whereas, the operation of Wisconsin Physicians Service and of all other prepayment programs of the State Medical Society has been directed at all times by the Council of the Society, with the knowledge and approval of the House of Delegates; and

"Whereas, the Commission on Medical Care Plans is a committee of the Council of the State Medical Society, and such Commission is composed of twenty-two members representative of every geographical section of the state, and some of said Commissioners have been associated for ten years or longer with Wisconsin Physicians Service, or with other prepayment programs established, operated or fostered by the State Society; and

"Whereas, the operation of Wisconsin Physicians Service has had at all times the constructive, loyal and devoted administration of the employed management of the Society, and the creative assistance of actuarial, accounting and legal consultants employed by the Society to assist in carrying out policies fixed by the House; now therefore

"Be it resolved, that at this time, when Wisconsin Physicians Service has undertaken all selling, administrative and other phases of its program, in addition to those earlier handled by it, the Commission express its deep appreciation of and complete confidence in its chairman, its general manager, the staff and consultants, for their sustained and devoted efforts in helping assure the success of this integrated program which has been established by the medical profession of Wisconsin in an effort to find a practical solution to the economic incidence of medical and surgical care."

b. Dental benefit rider

The Commission requested authority to proceed with the drafting of an oral surgery rider, separately rated, which would provide payment of the customary, usual and reasonable charges of doctors of dental surgery, up to a stated maximum, for subscribers receiving such services on advice of a physician rendering treatment for an accident or illness.

On motion of Doctors Hill–Leahy, carried, extension of benefits into this area was authorized.

c. Operational reports on Medicare and Home Town Care of the Veteran

Formal reports on these two governmental programs administered by the Society through the Commission on Medical Care Plans were distributed to the Council, which requested their circulation to the House of Delegates.

7 Resolutions filed after the deadline provided in the bylaws

a. Waupaca County Medical Society

The Council felt that this resolution, concerning activities of state mobile x-ray units, should receive consideration by the Division on Chest Diseases of the Commission on State Departments and that its referral to the House would be premature.

On motion of Doctors Hill–Kilkenny, carried, it was referred to the Commission on State Departments for study and subsequent report.

b. Winnebago County Medical Society

Its resolution concerned the Forand and similar bills and was similar to another resolution already introduced. Consequently, the Secretary had sent it to the reference committee and recommended that the Council formally refer it to the House.

On motion of Doctors Bell–Hill, carried, the Council approved referral of the Winnebago County resolution to the House of Delegates.

c. Manitowoc County Medical Society

On motion of Doctors Heidner–Dessloch, carried, its resolution concerning formulation in advance of a plan of distribution in event of some development such as the Asiatic flu vaccine, was referred to the House of Delegates.

A second resolution referring to the Society's legislative counsel had subsequently been withdrawn, and in this regard the Secretary reported that the Executive Committee proposed to meet with Manitowoc County officials.

On motion of Doctors Heidner–Hill, carried, such meeting was approved by the Council.

8. Report on Grievance Committee Procedures

Following the request of Doctor Ekblad at the last meeting, Mr. Murphy reported on the circumstances in a neighboring state leading to the creation of an advisory committee within the medical association to assist physicians faced with liability actions. After Mr. Crownhart explained how the same result is accomplished informally in Wisconsin through the existing committee, the Council, on motion of Doctors Ekblad–Hill, carried, concluded not to pursue further a change in procedure.

9. Certification of Clinical Psychologists

It appeared that this group would renew legislative efforts to secure certification in Wisconsin. Mr. Crownhart reported that the American Medical Association, American Psychiatric and Psychoanalytical Associations opposed certification or licensure.

On motion of Doctors Dessloch–Hill, carried, the matter was referred to the Committee on Public Policy with the Council's advice that statutory certification or licensure be opposed.

The Council recessed until 9:10 a.m. Monday, May 5, 1958.

10. Proposed Treatment Center for Disturbed Children

Mr. Thayer reported on meetings between the Division on Nervous and Mental Diseases and its subcommittee on the disturbed child, University of Wisconsin Medical School representatives, Department of Public Welfare, State Board of Health and others, on the extent of the problem, the need for facilities for treatment, training, and research. Out of these meetings has come general agreement that there is need for a treatment center for emotionally disturbed children, and an associated need for psychiatric training and research.

The Division recommended Society support of this proposal on the basis that:

(a) Initial planning provide for a capacity of 25–30 beds, to be expanded later as experience and staffing permit.

(b) The center should preferably be located as close as possible to the University of Wisconsin Medical School and Wisconsin Diagnostic Center.

(c) The center should be closely allied to the medical school for teaching and research purposes and planning should provide for a close interrelationship between the State Department of Public Welfare and the Medical School.

(d) Admissions to this treatment center should be permitted by referral from private and other sources as well as through routine commitment procedures.

On motion of Doctors Dessloch–Heidner, carried, the Council approved the proposal in principle.

11. Chiropodists and the Workmen's Compensation Act

Since the Council last considered this subject, the Industrial Commission, on petition of the Wisconsin Society of Chiropodists, had issued an opinion that the Wisconsin statutes permit chiropodists to treat claimants under the workmen's compensation act "without the necessity of a referral by other medical physician or surgeon."

On motion of Doctors Houghton–Conway, carried, this matter was referred to the Scientific Committee for further study and report.

12. Recommendations of Division on Safe Transportation

The Council had declined to take action on these recommendations at its last meeting, wishing further opportunity to consider them. After reviewing them again, the recommendations reported in the hand-

book for delegates by this division of the Commission on State Departments were accepted on motion of Doctors Conway–James, carried.

13. Recommendations of the Secretary

(a) That the Council recommend to the House of Delegates a bylaw amendment to require filing of resolutions in the secretary's office no later than 30 days prior to the first session of the House, instead of the present requirement of 20 days, to permit more time for their reproduction, distribution, and consideration by the delegates.

On motion of Doctors Hill–Bell, carried, this recommendation was approved.

(b) That the Society staff be authorized to arrange, in cooperation with the councilors, a schedule of annual delegate caucuses by districts, so arranged as to avoid duplication of staff travel, and including the preparation and mailing of notices; and that the expense of one annual caucus in each district be borne by the State Society.

This recommendation was approved on motion of Doctors Hill–Garrison, carried.

(c) That in arranging these meetings next year, the delegates be reminded of action by the House in 1945 "that it shall be the duty of the councilor of each of the several districts . . . to call a meeting of the delegates of each and every district not less than twenty days before the convening of the House of Delegates."

On motion of Doctors Bernhart–Houghton, carried, this recommendation was approved.

(d) That a special caucus of section delegates, alternates and officers of sections be arranged, since they are recognized members of the House with an interest in Society affairs, and often are not invited to the district meetings.

On motion of Doctors Bell–Conway, carried, this recommendation was approved.

14. Commission on State Departments Elections

a. General chairman to succeed T. W. Tormey, Jr., M.D.

Doctor Tormey was nominated for re-election by President Kasten and Chairman Arveson, and on motion of Doctors Bell–Hill, carried, was unanimously elected to succeed himself as general chairman.

b. Division chairmen

Election of division chairmen was laid over to the following day when, on separate motion duly made, seconded and carried, all division chairmen were re-elected except that George Nadeau, M.D. was elected chairman of the Division on Visual and Hearing Defects to succeed Maxine Bennett, M.D., who asked to be relieved of the chairmanship.

15. Council Resolutions

On motion of Doctors Dessloch–Bernhart, carried, the following resolutions were unanimously adopted by the Council:

a. Minnesota State Medical Association

Whereas, the Minnesota State Medical Association has tendered a contribution to aid in the creation of the Wisconsin Museum of Medical History at Prairie du Chien, and

Whereas, this contribution is significant of the limitless interest in medical history and the location of this important educational institution in an area of benefit and meaning to all of north central United States; now, therefore, be it

Resolved, that the Council of the State Medical Society of Wisconsin express to the Minnesota Association its sincere appreciation for this act of professional neighborliness and good will, and be it further

Resolved, that notice of this resolution commending the thoughtfulness and generosity of the Minnesota State Medical Association be provided all members of the State Medical Society of Wisconsin through its publication in THE WISCONSIN MEDICAL JOURNAL.

b. Elizabeth Comstock, M.D., Arcadia

Whereas, Dr. Elizabeth Comstock of Arcadia, now practicing for the fifty-seventh year, holds an unusual record of participation in the affairs of the State Medical Society, including regular attendance at the Annual Meeting and the circuit clinics, and

Whereas, her leadership, personal support and donations of family records and memorabilia constitute a unique contribution to the preservation of medical history and the establishment of the Wisconsin Museum of Medical History; now, therefore, be it

Resolved, that the officers and councilor of the State Medical Society, by their signatures hereto, express to Doctor Comstock their highest regard and most sincere appreciation for her unstinting devotion to finest traditions of the medical profession in serving the public and improving the profession.

c. Wilson Cunningham, M.D., Platteville

Whereas, a past-president of the State Medical Society of Wisconsin, Dr. Wilson Cunningham of Platteville, is deservedly regarded as the "father of medicine in Southwestern Wisconsin," and

Whereas, Doctor Cunningham gave freely of his time and talents to the profession and to his patients, as evidenced by his 30 years of service as a Councilor and more than half a century in active medical practice, and

Whereas, his generosity toward the Wisconsin Museum of Medical History marks a milestone

in its creation and establishes an incentive for all physicians to contribute in good measure according to the dictates of their conscience and ability; now, therefore, be it

Resolved, that the Council of the State Medical Society of Wisconsin extend to Doctor Cunningham, as a distinguished member emeritus, its profound appreciation for an act of immeasurable consequence to the perpetuation of the great ideals of medicine.

16. Costs of Insurance Controversy

The Executive Committee recommended Council approval of the proposal that costs associated with the current controversy over prepaid insurance, not yet determined in total, be absorbed within the Society dues structure and not borne by subscribers to Blue Shield from premium income.

On motion of Doctors Hill–Houghton, carried, this recommendation was approved.

17. Physicians' Blue Cross group coverage

A number of physicians subscribing to Blue Cross through the Society group had requested an increased allowance toward private room accommodations in a hospital. Blue Cross had advised that this was possible by rider to the current contract, which provides a $7.50 indemnity toward the private room rate.

The Executive Committee recommended that a poll of physicians be taken and if a majority should choose a $15 private room allowance, then the entire group would be issued the rider and charged the increased rate.

On motion of Doctors Hill–Houghton, carried, this recommendation was accepted.

18. Plans for "Wisconsinite" at San Francisco

In anticipation of a large attendance at the reception honoring Doctor Gundersen upon his inauguration as president of the American Medical Association, the Executive Committee had approved a budget to cover costs of the reception, staff travel, and other expenses.

19. Commission on Medical Care Plans

In creating the Commission, the Council had provided that its members must be participating physicians in the prepaid plans of the Society.

With increasing emphasis upon the "no fee schedule" concept in the Society's insurance plans, which does not involve full payment within defined income limits and thus participation is not required, and in the belief that representation on the Commission by nonparticipating physicians could be helpful in its deliberations, the Executive Committee recommended that this requirement be rescinded.

On motion of Doctors Hill–Dessloch, carried, this recommendation was approved by the Council.

20. Action upon Report of Executive Committee

On motion of Doctors Bell–Ekblad, carried, the Council accepted the several actions of the Executive Committee reported by the Secretary at the beginning of the meeting.

The Council then recessed until Tuesday noon, May 6, call to order at 1:20 p.m.

In addition to discussion and action on Tuesday already recorded in these minutes, the Council took the following action:

21. Albion H. Heidner, M.D.

Doctor Heidner announced that he was retiring after many years of enjoyable service on the Council.

On motion of Doctor Bernhart, variously seconded and unanimously carried, the Council extended a vote of thanks to Doctor Heidner for his tremendous contributions to the Society, with a wish for Godspeed and many happy years.

22. Adjournment

The Council adjourned at 2:30 p.m. on May 6, 1958.

C. H. Crownhart,
Secretary

Approved:
R. G. Arveson, M.D.
Chairman of the Council

Minutes of Special Joint Meeting of Council and Commission on Medical Care Plans, Madison, June 4, 1958

1. Call to Order and Roll Call

The meeting was called to order by Dr. R. G. Arveson, chairman of the Council, at 9:30 a.m. on Wednesday, June 4, 1958, at Society headquarters in Madison.

A roll call of the Council showed the following voting members present: Doctors James, Hill, Houghton, Dessloch, Blanchard, Kief, Fox, Bell, Garrison, Arveson, Bernhart, Conway, Leahy, and Past-president Kasten. Also present were Doctor Fons, president; Doctor Witte, AMA delegate; Doctor Simenstad, AMA alternate delegate; and Doctor Gundersen, president-elect of the American Medical Association.

The following members of the Commission on Medical Care Plans were present: Doctors Carlson, Casper, Davis, Dessloch, Doege, Garrison, Hill, Mason, McCarey, Reznichek, Sprague, Supernaw, Wolf, and Fons.

Staff and consultants: Messrs. Crownhart, Thayer, Doege, Thatcher, Misses McGruer and Pyre; Messrs. Murphy and Gavin, legal counsel; Gill, certified public accountant; Tiffany, consulting actuary.

2. Purpose of Meeting

The meeting had been called by Doctors Arveson and Dessloch, chairmen, respectively, of the Council and Commission, to consider problems created by the May 26, 1958, decision of the Board of Directors of The Medical Society of Milwaukee County to permit the sale of Surgical Care by Blue Cross in ten counties surrounding Milwaukee County.

3. Statement by Doctor Fons

Doctor Fons asked for the privilege of making an opening statement to the joint meeting to explain his position with respect to the action taken by the Milwaukee Couny Board, of which he is a member, and against which action he voiced the one negative vote out of five. He said he had voted against it because as a member of the medical profession in Wisconsin he could see no moral justification for the action in view of the fact that the Board knew it was the stated position of Wisconsin Physicians Service that it had no intention of entering Milwaukee County with its programs; secondly, that Doctor Fons had been assured by officials of Blue Cross at a meeting with the Milwaukee Board, that it would not sell any other type of prepaid medical-surgical coverage within Milwaukee County if it was permitted to continue the sale of Surgical Care in that County.

4. Discussion and Action

Following a period of open discussion and statements by Milwaukee representatives and others that it would be well to arrange a meeting of members of The Milwaukee County Medical Society to hear a full presentation of the total problem so that such members could have opportunity to either reject or uphold the action of the Board of Directors, the following action was taken:

A proposed statement of the Council as to the problem facing the State Medical Society as a result of the Milwaukee County Board action, which was intended to state the underlying reasons for whatever emergency action the Council and Commission found it necessary to take at this meeting, was laid over for future action to allow opportunity for a meeting of the Milwaukee County society.

Two resolutions were unanimously adopted:

A. "Resolved, that the Commission on Medical Care Plans of the Council of the State Medical Society be and hereby is authorized to engage in the writing and sale of hospital cost coverage necessary to protect the programs of Wisconsin Physicians Service."

The above resolution was adopted in recognition of the fact that the sales staff of Wisconsin Physicians Service is faced with active competition of Blue Cross—Surgical Care in territory of the former where it has substantial installations, and in knowledge of the fact that Blue Cross still is negotiating on other methods of competing with surgical-medical coverage in WPS territory.

B. "Resolved, that the Board of Directors as well as members of The Medical Society of Milwaukee County be and hereby are informed that the State Medical Society, by action of its Council, disapproves action of the Board of Directors of the Milwaukee county society in extending operation of Surgical Care, the Blue Shield plan of such society, owned, operated, and directed by it, beyond the original area of sale, *i.e.*, to Milwaukee installations and to payroll originating in Milwaukee County."

A number of other resolutions dealing with various attendant aspects of the problem were introduced to the Council and laid over for subsequent action.

The question of calling a special session of the House of Delegates on this matter was also laid over to the July meeting of the Council, or an earlier meeting if developments indicate the call of a special meeting.

The Council approved enlargement of the Commission on Medical Care Plans from 20 to 26 appointed members.

The Council approved the Secretary's recommendation that there be no change in the present policy of recommending Blue Cross, of enrolling Society employees in the plan and encouraging physicians to enroll in it, and that consideration of such policy be taken up at the next regular or special meeting of the Council.

Also laid over was the matter of a management survey of the State Medical Society, requested by resolution of Milwaukee County and referred to the Council by the House of Delegates at the May 1958 meeting.

Finally, the Council authorized the Secretary to employ an insurance consultant to help implement carrying out the authority granted in Resolution A adopted at this meeting.

5. Adjournment

The meeting was adjourned at 2:45 p.m.

C. H. Crownhart,
Secretary

Approved:
R. G. Arveson, M.D.,
Chairman of the Council

Minutes of Council Meeting, Land O'Lakes July 25–26, 1958

1. Call to Order and Roll Call

The meeting was called to order by Chairman Arveson at 3:10 p.m. on Friday, July 25, at King's Gateway, Land O'Lakes, Wisconsin.

Councilors present: Doctors Lokvam, Hill, Houghton, Dessloch, Blanchard, Kief, Fox, Bell, Arveson, Bernhart, Conley, Conway, Galasinski, Leahy, Kilkenny (Friday only), James (Saturday only), and Past-president Kasten. Officers and others: Doctors Fons, president; Hildebrand, president-elect; Witte, Stovall, and Simenstad, delegates to the American Medical Association; Bowers, dean of the University of Wisconsin Medical School.

Staff and consultants: Messrs. Crownhart, Thayer, Doran, Koenig, Doege, DuBois, Misses McGruer and Pyre; Messrs. Murphy, legal counsel; Tiffany, consulting actuary; Gill and White, certified public accountants.

2. Introduction of New Business

Doctor Galasinski, speaking for the Milwaukee councilors, presented the request of the Milwaukee County medical society that the financial statement of Wisconsin Physicians Service be published monthly in THE WISCONSIN MEDICAL JOURNAL or through some other means. This request, by agreement, was laid over.

He also asked that study be given to the interprofessional code recently adopted by the AMA to see whether it might have beneficial application in Wisconsin to relationships with the State Bar of Wisconsin.

3. Staff Report on Wisconsin Physicians Service

At the request of the Secretary, and on motion of Doctor Fox, seconded and carried, the Council agreed that the report and discussion be conducted in executive session, with the minutes showing only actions or conclusions.

The Council discussed the controversy between WPS and the Blue Cross–Milwaukee County programs Friday afternoon and evening, and continued on Saturday after reconvening at 9:35 a.m. The following motions, introduced by a committee appointed by Chairman Arverson composed of Doctors Hill, Galasinski, and Dessloch, were acted upon Saturday morning, July 26, 1958:

a. Motion of Doctors Hill–Blanchard, carried:
   In view of the fact the gentlemen's agreement has been violated, the State Medical Society is authorized to sell sickness insurance in the entire state by Wisconsin Physicians Service.

b. Motion of Doctors Hill–Fox, carried:
   There shall be called a meeting of the House of Delegates for the express purpose of complete information and study of the philosophy and policies of prepaid medical care programs in Wisconsin; such meeting to be held within approximately eight weeks, and to be held in a location outside Milwaukee or Madison, if at all possible.

c. Motion of Doctors Hill–Lokvam, carried:
   The only Blue Shield plan approved by the State Medical Society is Wisconsin Physicians Service, for sale in the entire state.

The Secretary then asked that authority be granted him to consider the State Society employees and physicians groups, currently enrolled in Blue Cross for hospital protection, as "competitive groups" which may be "solicited" for enrollment in the WPS hospital plan.

On motion of Doctors Lokvam–Fox, carried, such authority was granted.

4. Codification of Official Society Pronouncements

The Secretary reported a suggestion made to him in light of the current problem facing the medical profession necessitating a special session of the House of Delegates, that official positions, actions, pronouncements of past years be codified, modernized where necessary, and reported to the House of Delegates for its action and publication in THE WISCONSIN MEDICAL JOURNAL as a reminder to the members. Examples of such positions, simply stated, are:

Issues involving quackery and charlatans shall not be compromised.

Corporate practice of medicine shall be avoided in all its forms.

Compulsory health insurance, no matter its form, is opposed.

Radiology, anesthesiology, pathology and physiatry are the practice of medicine.

On motion of Doctor Fox, seconded and carried, this proposal was referred to the Executive Committee for subsequent report to the Council and ultimate consideration by the House.

5. Committee on Hospital Relations

The program of hospital relations supported by an increase in dues approved by the House of Delegates in 1957 on joint recommendation of the Committee on Hospital Relations and the Council on Medical Service, began taking effect early in 1958. A formal report on this project would normally not be scheduled until the 1959 meeting of the House of Delegates. However, its financial impact requires evaluation in preparation of the 1959 budget early in the year, and it was therefore recommended that the

Council request a report on this project sometime in the fall of 1958. On motion of Doctors Bell–Dessloch, carried, the recommendation was accepted.

6. Councilor District Reports

On motion of Doctor Lokvam, variously seconded and carried, these reports, scheduled for this meeting in March, were laid over to a later Council meeting.

7. Reports by Consultants

a. Donald E. Gill, certified public accountant

Mr. Gill reported on the three functions performed by his firm as consultants to the State Medical Society:

(1) Auditing, in which capacity there is no limit on their activities in taking the steps necessary to audit the accounts of the Society and its divisions. In connection with this portion of the report, a copy of the consolidated audit report of all divisions for 1957 was distributed to the Council.

(2) Making recommendations to the Secretary from time to time of administrative changes affecting accounting procedures or Society finances.

(3) Undertaking specially assigned projects requiring assistance of the certified public accountants.

Mr. Gill was asked whether he could make an unqualified statement that the financial structure was presently very sound, to which he answered in the affirmative.

b. Carl A. Tiffany, consulting actuary

Mr. Tiffany explained that his responsibility was concerned with the rates charged for the various benefit contracts sold by Wisconsin Physicians Service. In summary, he reviewed the factors which must be considered in his final judgment as to rates, necessitating knowledge of other phases of the insurance operation, such as drafting of contract terminology and its interpretation by administration, the enrollment and underwriting regulations, and the statistical experience under the various contracts at the rates established.

c. Robert B. Murphy, attorney-at-law

Mr. Murphy described the responsibilities of the firm of Murphy, Gavin, Stolper and Desmond in the Society as a corporation, the legal or tax implications of its various activities or policies, personal and property insurance matters, its Constitution and Bylaws; as an employer, the Workmen's Compensation Act, wages and hours laws, retirement program; and as a provider of personal services to members and to the public.

He summarized their assignments in connection with the health care programs of the Society, with legislative matters, state and federal, with associated organizations such as the Foundation and Realty Corporation, and in attending most Society meetings to keep abreast of the broad range of activities and watch their legal implications.

8. Retirement programs for the self-employed

Mr. Murphy presented the following proposed resolution for Council consideration relating to pending federal legislation which would provide tax consideration for the self-employed in the establishment of retirement programs:

Whereas, bills have been pending before the Congress for several sessions which are designed to permit the self-employed, including the vast majority of physicians, to enjoy the same privileges of establishing savings for retirement years, on a deferred income tax basis, as has been permitted employed persons since 1942; and

Whereas, such prior proposed legislation met with heavy opposition from governmental and other sources which prevented its enactment; and

Whereas, the organization of some twenty groups or representatives of the self-employed, including the American Medical Association, into the Thrift Assembly, has permitted a more effective presentation of the discrimination now suffered by the self-employed, in contrast with employed persons in this country, in the matter of tax deferred retirement programs; and

Whereas, one of the consequences of this inequality in treatment of the self-employed has been a series of efforts to obtain such tax recognition through the reorganization of professional groups, including physicians, into associations, so as to enable them to be treated for tax purposes as corporations, and to enable their members to be treated as employees; which efforts have generally met with opposition from the United States Treasury, and have enjoyed very limited success; and

Whereas, it has recently been announced that the House Ways and Means Committee has agreed to report favorably a bill permitting the self-employed to defer income taxes on payments made to retirement funds under specified conditions, but as yet it is not certain what precise form such legislation will take, although it should follow upon the principle of the Jenkins–Keogh bills, and, according to present understanding, will permit a self-employed person to set aside up to ten per cent of his earned income, not to exceed $2,500 per year, in government bonds, certain types of insurance, or specified investments, and to defer any income tax on such amounts until they are withdrawn; now, therefore, be it

Resolved, that the Council of the State Medical Society again extend its support to this type

of legislation, and immediately so advise the entire congressional delegation of Wisconsin, strongly urging its passage in some form before the current session adjourns; and be it further

Resolved, that the general membership of the State Medical Society be advised of these developments, and strongly urged to contact their respective congressmen and the two senators, and to urge the enactment of this type of legislation as a matter of basic fairness, and to cure this tax discrimination against the self-employed.

On motion of Doctor Bernhart, seconded and carried, the above resolution was adopted by the Council.

9. Medicare

Mr. Crownhart reported information just received that federal legislation was imminent which would cut back funds for administration of the Medicare program, and that an amendment was being introduced by Senator Knowland to restore the funds so that the program can be continued as originally contemplated, with services available from private sources and not limited to military facilities.

On motion of Doctors Bernhart–Hill, carried, the Council asked that support of the Knowland amendment be requested of the Wisconsin senators.

10. National Public Assistance Programs

The American Medical Association at its 1958 San Francisco session, requested that state societies consider an administrative policy as to any funds provided under public assistance provisions of the Social Security Act for medical care of the indigent.

On motion of Doctors Hill–Conway, carried, this matter was referred to the Commission on Medical Care Plans for study as to its future implementation.

11. Report of Scientific Committee of the Council

This committee met on July 25, and Doctor Bell, chairman, reported as follows:

a. Plan for Consultation Practice at U. W. Medical School

Doctor Bowers has sought to keep the Society informed of developments at the University of Wisconsin Medical School. In this he has worked closely with the Society's Committee on Coordination of Medical Services. Recently with that committee, and again with the Scientific Committee, he reviewed a plan involving salary structures and consultation practice at the University. This plan has been informally approved by the University, but its full implementation cannot be secured until the Wisconsin Legislature provides funds to assure the various income levels established by the plan.

At Doctor Bell's request, Dean Bowers summarized the plan and said he wanted the Council to know of it and that suggestions and criticisms were welcomed. He reported that review of the plan with the Scientific Committee had been helpful.

No action was taken by the Council.

b. Promotional device of a commercial exhibitor

The committee recommended, and the Council agreed, that the opinion of the American Medical Association be requested as to the propriety of accepting an annual meeting exhibit by a company which provides an insurance policy against premature labor and stillbirth for patients whose physicians prescribe the company's dietary supplement in pregnancy.

c. Use of pitocin

The committee recommended, and the Council agreed, that an inquiry from the State Department of Nurses as to the responsibility of a nurse administering pitocin drip without direct physician supervision be considered a matter of medical practice and referred to the Division on Maternal and Child Welfare, which has been conducting postgraduate programs on this subject.

12. Matters of Public Policy

a. Polk County mental health program

A news clipping was noted that Polk County had hired an individual trained in psychiatric social work as "county psychiatrist" to work with an advisory committee which had no physician representation.

Council members from the area did not feel there was any problem locally, and the matter was tabled.

b. National Foundation for Infantile Paralysis

Apparent plans of this Foundation to expand its activities into the field of medical care were referred to the Commission on Medical Care Plans, on motion of Doctors Bernhart–Houghton, carried.

c. Treatment center for emotionally disturbed children

Mr. Thayer reported as to progress in discussions of a state treatment center by the Legislative Council which, for the most part, follows the recommendations joined in by the Division on Nervous and Mental Diseases and previously reported to the Council.

The Council agreed that the Committee on Public Policy should follow this matter closely.

13. Report of Finance Committee, July 25 meeting

a. 1957 Audit Reports

While the Council had received a consolidated summary audit report of all activities for 1957, the committee reviewed the following detailed audits: State Medical Society; Wisconsin Physicians Service; Dependents Medical Care

Plan; THE WISCONSIN MEDICAL JOURNAL; Veterans Medical Service Agency; SMS Realty Corporation.

b. Salary adjustment

The committee approved an increase of $1,500 in Mr. Ragatz's salary (part-time) effective July 1, 1958.

c. Per diem allowance for July meeting expenses

In order to simplify the bookkeeping, and as an experiment, the committee approved a per diem allowance for each day of an official Council or committee session, to be credited against the total bill for individual physicians attending this meeting.

d. Investment of pension funds

Meeting as trustees of the pension plan, the Finance Committee discussed the problem of investing the funds accumulated monthly through Society and employee contributions. The committee authorized the continued investing of these funds in government bills as accumulated, and recommended that an investment counselor be retained to advise on the total investment picture of the Society on a semiannual basis.

On motion of Doctors Lokvam–Hill, carried, the report of the Finance Committee was accepted.

14. Report of Executive Committee

The committee met July 24 and 25, and in its behalf the Secretary reported as follows:

a. U. S. Workmen's Compensation Act

Under this Act free choice of physician is restricted by reason of a limited panel. The Executive Committee recommended study of the situation and the possibility of the Wisconsin delegates to the American Medical Association introducing a resolution seeking amendments of the federal law to provide wider choice.

On motion duly made, seconded and carried, the Council approved this recommendation.

b. Management survey and related matters

The committee had devoted preliminary discussion to the request of the Reference Committee on Resolutions at the May 1958 annual meeting, in rejecting Milwaukee Resolution 8, that the Council "consider the desirability of authorizing and implementing such a study . . ." It noted steps taken in the past for the purpose of streamlining Society committee activities, such as creation of the Commissions on Medical Care Plans and on State Departments, and the recent reorganization of the Council itself. The Secretary also reported that he is continuously directing studies of internal administrative operations and instituting revised practices on recommendation of the consultants or from within the administrative staff. He said this was an active matter which remains on the Council agenda for further reports and recommendations.

The Executive Committee recommended that in connection with a review of Society management the constitution, bylaws and regulations of all county medical societies should be called in for study. Not only should the county constitution and bylaws be consistent with those of the State Society, but the consistency of any regulations, such as extension of membership privileges to special classifications, should also be reviewed. The State Society constitution and bylaws should also be studied in such a total policy-level review.

c. Secretary's report of administrative planning

The Secretary reported to the Council, as he had to the Executive and Finance Committees, that he anticipated the employment in the fall of a hospital administrator whose knowledge of hospital administrative problems would be useful in planning and administering the hospital benefits of Wisconsin Physicians Service.

As to the hospital costs study authorized by the Council, he reported his thinking that this new employee, together with the other hospital administrator employed at the beginning of the year to work on the project recommended by the Committee on Hospital Relations and the Council on Medical Service, could conduct a pilot study on the costs of hospitalization using various sized hospitals, rural and urban. He explained the difficulties met in trying to secure the funds necessary to conduct a statewide study.

d. Board of Directors of National Blue Shield

The Executive Committee concurred in the proposal that the Commission on Medical Care Plans consider sponsoring a change in the bylaws of Blue Shield Medical Care Plans to provide that membership on the board of directors be confined to doctors of medicine, to insure medical leadership and control at the national level.

e. Resolution of Wisconsin Society of Pathologists

The committee recommended Council approval of the following resolution concerning practice of cytotechnology:

"Whereas, the contributions of cytology to the diagnosis and treatment of uterine carcinoma are both obvious and important, and

"Whereas, the values of such contributions depend entirely upon the adequate control of the quality of the work done, and

"Whereas, because of the increasing complexity of both laboratory and clinical medicine, the laboratory worker is frequently called upon to consult with and advise a practicing physician, and

"Whereas, both the public and the practicing physician frequently fail to understand the difference between a laboratory physician and a medical technologist, and

"Whereas, the benefits to the patient are much greater when laboratory consultations to the practicing physician are given by persons adequately trained in the techniques of both the laboratory and medicine, be it

"*Resolved*, that the best interests of the general public are served when actual control of all laboratories using cytological technique for the diagnosis of disease be confined to individuals with the degree of Doctor of Medicine and preferably to those physicians who have specialized in the branch of medicine known as Pathology and Clinical Pathology."

On motion of Doctors Hill–James, carried, this resolution was approved by the Council.

15. Plans for Special Meeting of House of Delegates; Related Costs

The Secretary said he assumed action of the Council in May, that costs related to the controversy over insurance plans be borne by the dues and related income of the Society and not by subscribers to Blue Shield, was not confined to that period, but would extend to costs of the special session, distribution of material, special meetings, etc.

He also proposed that planning for the meeting be delegated to a smaller group. Such matters as the location and date, what information to be provided and by whom, what motions may be introduced, who may appear before the House, among others, must be decided.

On motion of Doctors Bernhart–Fox, carried, formulation of arrangements for the special meeting was assigned to the Executive Committee.

16. Miscellaneous suggestions of Secretary

There was general agreement with the suggestion that a letter be prepared for signature by councilors to members in each district reporting action of the Council at this meeting relating to Blue Shield.

Second, on motion of Doctors Dessloch–Bernhart, carried, the Council agreed that a meeting be held in the vicinity of West Bend to pay tribute to Doctor Heidner, councilor emeritus of the fifth district, for his 30 years of service on the Council.

17. Adjournment

The meeting adjourned at 2:50 p.m. on Saturday, July 26, 1958.

C. H. Crownhart,
Secretary

Approved:
R. G. Arveson, M.D.,
Chairman of the Council

Minutes of Special Council Meeting, Madison September 13, 1958

1. Call to Order and Roll Call

The meeting was called to order by Chairman Arveson at 2:15 p.m. on Saturday, September 13, 1958, at Society headquarters in Madison.

Councilors present were Doctors James, Lokvam, Hill, Houghton, Dessloch, Blanchard, Kief, Bell, Garrison, Arveson, Ekblad, Bernhart, Conley, Galasinski, Leahy; officers and others: Doctors Fons, president; Hildebrand, president-elect; Weston, treasurer; Witte and Stovall, AMA delegates; Heidner, councilor emeritus; members of the Commission on Medical Care Plans: Doctors Davis, Hilker, Krohn, McCarey, Nordby, Simenstad, Sprague, and Supernaw.

Staff and consultants: Messrs. Crownhart, Thayer, Ragatz, Doran, Doege, Koenig, DuBois, Farrel; Misses McGruer and Pyre; Messrs. Gill, Murphy, Desmond, Toser, and Robison.

2. Wisconsin Hospital Association Bulletin

There was distributed to the Council a bulletin from the Wisconsin Hospital Association dated in July and addressed to administrators of institutional members. It was titled, "Charging for Services of Medical Specialists Employed by Hospitals," and concerned the Wisconsin "fee splitting statute," Section 147.225 (3). This was accompanied by an analysis prepared by Murphy, Gavin, Stolper and Desmond on September 10, which pointed out an important omission in the statutory quotation contained in the Hospital Association memorandum. A further error was noted in that the Hospital Association bulletin, which appeared to legalize the employment on a salary of a radiologist or pathologist by a hospital and the billing by the latter of charges for the professional services rendered by such employees, used in its interpretation an attorney general's opinion rendered in 1914, whereas the statute referred to was amended in 1915. Of the statutory omission in the Hospital Association memorandum, the reply opinion prepared by the Society's legal counsel says: "The wording which has been omitted is the language which precisely requires that when a hospital or a physician makes a charge, each must render a bill directly to the patient which is distinct and separate from that

rendered by any other person, firm or corporation."

Following discussion, and to insure that this erroneous advice be brought to the attention of those particularly interested at the earliest possible time,

On motion of Doctors Hill–Ekblad, carried, the Council authorized distribution of this comparison opinion to all Wisconsin hospital administrators and chiefs of staff, to radiologists, pathologists, and anesthesiologists, and to the House of Delegates.

This motion was amended by Doctors Lokvam–Bell, carried, that the Society will aid its membership in interpretation of the policy stated therein.

3. Procedures for Special Session of House of Delegates

The Executive Committee, which met in August to take up the assignment given it by the Council in July to make arrangements for the Special Session, recommended that the Council in turn recommend to the House:

> a. Adoption of a special rule to the effect that material for its consideration can be filed no later than its initial session, or before the Reference Committee. The second session of the House would then refuse any last-minute material.

On motion of Doctors Ekblad–Houghton, carried, this recommendation was accepted.

> b. That the Reference Committee, in the conduct of its hearings, should permit those not associated with the medical profession to appear before it only by committee invitation.

On motion of Doctors Lokvam–Blanchard, carried, this recommendation was accepted.

4. Matters for Council consideration relative to its reporting to the Special Session of the House

a. Council actions since the May meeting of the House

On motion of Doctors Garrison–Bell, carried, the Council approved reporting the following actions to the House:

> (1) In June 1958 the Council voted disapproval to the action of The Medical Society of Milwaukee County in extending its operations beyond the borders of the county medical society's jurisdiction.
>
> (2) In June 1958 the Council authorized its Commission on Medical Care Plans to provide the medical-surgical contracts with companion hospital benefits.
>
> (3) In July 1958 the Council adopted a formal statement that Wisconsin Physicians Service is the only Blue Shield plan approved by the State Medical Society of Wisconsin for sale throughout the state.

b. Consideration of Special Reports by the Secretary

The Secretary reported these further actions taken by the Executive Committee on August 9, 1958:

> (1) That the call of the House permitted formal action by it.
>
> (2) That the call related to the plans operated by the State and county medical societies and the plans of Associated Hospital Service, Inc. and its Health Insurance Corp.
>
> (3) That it is the responsibility of the Secretary to prepare and distribute to the House information pertinent to the subject before it, with the understanding that its accuracy is solely the responsibility of the Secretary.
>
> (4) That the House should be informed that its members are free to consult with members of the Council, the Commission on Medical Care Plans, or any other individual who can contribute to their successful deliberations.
>
> (5) That in light of the above action, the Council would not be required to review the information emanating from the Secretary's office prior to its distribution; but that such material would be reviewed at this special meeting of the Council.

The Secretary reviewed the Special Reports distributed to date, and others contemplated, and asked the Council if there were comments or criticisms. None were offered.

c. Report on hospital program

Copy of the hospital rider had been distributed with the agenda, together with a brochure describing the companion surgical-medical-hospital program of Wisconsin Physicians Service.

The Secretary reported that with WPS now providing a combined surgical-medical and hospital program, there was opportunity to bring consistency as to benefits for physicians' and hospital services in the area of diagnostic benefits, both in- and outpatient. Under general authority of the Commission on Medical Care Plans and without final action upon the matter, the staff had been authorized to attempt a solution whereby benefits are always provided for physicians' services whenever the hospital rider provides benefits, either in the base contract or by rider, with payment to the source of billing.

d. Resolution of Medical Society of Milwaukee County

It was recommended that this resolution, which was the same as that considered by the House of Delegates in May 1958 except that it contained some new introductory "Whereases," be reported by the Council to the House as not pertinent to the call of the Special Session; that it is a matter already decided by action of the House in May, when the resolution was rejected and the subject of a management survey was referred to the Council for consideration; that the Council is at work upon the matter and has over the past decade made a number of management recommendations to the House of Delegates.

On motion of Doctors Garrison–James, carried, these recommendations were approved.

e. Resolution of Dane County Medical Society

Following discussion of the resolution, text of which will be found in the report of proceedings of the Special Session, Doctors Dessloch–Lokvam moved that it be transmitted to the House of Delegates with the endorsement of the Council. A roll call vote was requested, which resulted as follows: Doctors James, Lokvam, Hill, Houghton, Dessloch, Blanchard, Kief, Bell, Garrison, Arveson, Ekblad, and Leahy in favor of adoption; Doctors Bernhart, Conley, and Galasinski opposed.

f. Report of recommendations by the Secretary

The Secretary reported to the Council that out of numerous conferences and meetings with councilor districts, county societies, the Commission on Medical Care Plans, the Council Executive Committee, and others, had gradually evolved a series of "self-evident truths" concerning the Society's administration of medical care plans leading to the formulation of several recommendations relating to the problem before the Special Session of the House of Delegates. He said that these had been informally presented to the Commission and approved by it, and since then had been formalized for presentation to the Council.

He read the introductory statement of "truths" and a series of five recommendations which will be reported in the House proceedings. These were discussed by the Council, and Doctors Dessloch–Houghton moved that the Council adopt the Secretary's report and forward it to the House of Delegates as its own.

A roll call vote was requested, resulting as follows: Doctors James, Lokvam, Hill, Houghton, Dessloch, Blanchard, Kief, Bell, Garrison, Arveson, Ekblad, Conley and Leahy voted "aye"; Doctor Galasinski, "no"; Doctor Bernhart, "present."

g. Resolutions of the Commission on Medical Care Plans

Doctors Dessloch–Hill moved that the Council adopt the following two resolutions presented by its Commission on Medical Care Plans:

(1) *Resolved*, that the Council states that the activity of Surgical Care is approved for Milwaukee County only; that it has no approval to enter into any other areas of the state, and if it does, it is doing so in violation of Council action; and that the Insurance Commissioner of Wisconsin and the national organization of Blue Shield Medical Care Plans be so notified.

(2) Whereas, Surgical Care, the Blue Shield Plan of The Medical Society of Milwaukee County, is an activity of that society, wholly owned, directed and operated by it, and

Whereas, some physicians outside Milwaukee County have signed agreements as participating physicians in Surgical Care, and Surgical Care is conducting a continual solicitation of the remainder to become participating physicians, and

Whereas, the participating physicians of Surgical Care outside Milwaukee County have no voice or vote of any kind in Surgical Care policy determination, including such matters as fee determination and claims settlement, and

Whereas, participation without such representation is a mockery of professional sponsorship making the physician nothing more than a tool of the sales effort, and

Whereas, the membership standards of Blue Shield Medical Care Plans require that a professionally sponsored plan may not use the Blue Shield symbol or trade name unless it has at least 51% participation of the physicians in the area served by it; now, therefore, be it

Resolved, that the Council of the State Medical Society strongly recommends that each county medical society, except Milwaukee County, urge its members not to participate in Surgical Care of Milwaukee County inasmuch as they have no vote or control whatsoever in its policies and Surgical Care has defied the democratic vote of the Council of the State Medical Society by exceeding its agreed territorial limits, and be it further

Resolved, that the Council requests each county medical society, except Milwaukee, to conduct a democratic vote of its members by mail ballot within 30 days to determine whether or not 51% or more of the physicians in each county actually do wish to serve as participating physicians for Surgical Care, and be it further

Resolved, that in those counties where the poll reveals less than 51% of the physicians wishing to participate in Surgical Care, the county medical society notify Blue Shield Medical Care Plans of this fact and demand that Surgical Care cease the use of the Blue Shield symbol and trade mark in those counties.

Following discussion, the roll was called on the motion for adoption, as follows: Doctors James, Lokvam, Hill, Houghton, Dessloch, Blanchard, Kief, Bell, Garrison, Arveson, Ekblad, Bernhart, Conley and Leahy voted "aye", Galasinski, "no."

5. Medicare

Mr. Koenig reported on a conference in Washington on August 8 when the Office of Dependents Medical Care presented proposed changes in Medicare necessitated by a cutback in federal funds ordered by Congress, to become effective October 1. These changes not only would exclude certain categories of medical services, but would require greater use of military facilities.

He said that this matter had been discussed with the Commission on Medical Care Plans in August, which authorized a telegram to the President and the Wisconsin Senators protesting these changes and requesting a postponement in the effective date to

allow more time to review them and consider renewal of the contract with the government. Little satisfaction was received in the reply from Sherman Adams.

On motion of Doctors Galasinski–Hill, carried, the report was accepted.

6. Commission on Medical Care Plans

a. Creation of Committee on Hospital Contracts

Organization of the Commission is specified by the Council. Its approval was requested to creation of a new committee within the Commission to provide general supervision, study, and report with reference to the hospital contracts of WPS.

On motion of Doctors Bell–Bernhart, carried, the Council approved creation of a Committee on Hospital Contracts.

b. Commission assignments

Matters assigned the Commission by the Council involve a broad range of responsibilities, including operations of Wisconsin Physicians Service, the Wisconsin Plan, Home Town Care of the Veteran, Medicare, and others. This necessarily requires orderly procedures within the Commission itself, and the Secretary suggested the practical advisability of the Council stating a positive procedure of referral.

On motion of Doctors Garrison–Houghton, carried, the Council directed that all matters affecting the Commission's assignments be referred first to the Commission and then be brought to the Council after having Commission consideration.

7. Meeting of Council preceding Special Session

On motion of Doctors Conley–Ekblad, carried, the Council agreed to meet Saturday morning, September 27, 1958.

8. Adjournment

The meeting adjourned at 8:35 p.m., September 13, 1958.

C. H. Crownhart,
Secretary

Approved:
R. G. Arveson, M.D.,
Chairman of the Council

Minutes of Special Council Meeting, Stevens Point September 27, 1958

1. Call to Order and Roll Call

The Council was called to order by Chairman Arveson at 8:50 a.m. on Saturday, September 27, 1958, at the Whiting Hotel, Stevens Point, Wisconsin.

Councilors present were Doctors James, Lokvam, Hill, Houghton, Dessloch, Blanchard, Fox, Bell, Garrison, Arveson, Ekblad, Bernhart, Conway, Galasinski, Kilkenny, and Leahy.

Officers and others: Doctors Fons, president; Hildebrand, president-elect; Weston, treasurer; Witte, Stovall, and Simenstad, AMA delegates; Heidner, councilor emeritus; Paul Mason and Karl Doege; Messrs. Crownhart, Thayer, Murphy, Gavin, Desmond, Robison, Tiffany, Gill, White, Toser; T. A. Hendricks of the AMA; Misses McGruer and Pyre.

2. Greetings to Doctor Kasten

On motion of Doctor Galasinski, seconded and carried, the Council voted to send a message of greetings to Mrs. Kasten, and to Doctor Kasten, with a wish for a speedy recovery.

3. Executive Session

The Secretary requested opportunity to present two management matters to the Council in executive session involving several executive salary adjustments and disability insurance covering certain employees with the Society as beneficiary. On motion, these were approved with Doctor Kilkenny voting "no" on the basis that insurance was a management matter within the discretion of the Secretary.

4. Statement of Ohio State Medical Association on Corporate Practice of Medicine

The statement of the Council of the Ohio State Medical Association regarding unauthorized practice of medicine by partnerships, associations, institutions, corporations, unlicensed persons and the ethical status of physicians involved, had been distributed to the Council at its September 13 meeting for information only. It was suggested that it be referred to the Executive Committee for study and later recommendation to the Council.

On motion of Doctors Lokvam–Blanchard, carried, the Council so ordered.

5. Wisconsin Hospital Association bulletin

The Secretary proposed that in addition to the distribution authorized by the Council at its last meeting, the bulletin of the Wisconsin Hospital Association on, "Charging for Services of Medical Specialists Employed by Hospitals," and the analysis prepared by the Society's legal counsel also be sent to members of the State Board of Medical Examiners which has the responsibility of enforcing the Medical Practice Act.

On motion of Doctors Galasinski–Garrison, carried, the Council so ordered.

6. Further Possible Recommendations to Special Session of the House

a. Statement on Open Meeting

The staff recommended that the Council adopt a specific recommendation to the House that it state at the opening of the Special Session that its deliberations will not be conducted in executive session.

The following statement was proposed, and approved on motion of Doctors Galasinski–Garrison, carried:

"It has been stated, and with justification, that the programs of prepaid health care endorsed by physicians and by hospitals have grown to such dimensions that they now have become matters in which the public itself has a legitimate and personal interest.

"Such interest manifests itself in matters before this special session of the House of Delegates.

"This session has attracted state-wide as well as national attention.

"Individuals representing national organizations will be in attendance as observers.

"In addition, the press will be represented. Those known to the Council include reporters for the Madison Capital Times, the Milwaukee Journal, Milwaukee Sentinel, AMA News, Medical Economics, and the Stevens Point Journal. AP and UP will carry reports on their wire services. Photographers may be present as well.

"The Council believes that this House of Delegates should state immediately upon the opening of its sessions that its sessions will be open to the public, as will the hearing by the reference Committee. The latter should, of course, have opportunity to enter into executive session at the point appearances before it have ceased, in order that it may determine upon the contents of its report to the House on Sunday morning."

b. Interpretation of Hill–Burton Act

The Secretary reported that an interpretation of the Hill–Burton Act had just come to his attention which, while apparently made some time ago, recently had become known in local and national medical circles.

An official of the United States Public Health Service had ruled, in effect, that Hill–Burton funds "will not be granted for hospital construction if a hospital plans to rent or lease its department of radiology." If, however, the radiologist is providing "services for the hospital and not as a private physician" such funds would be available. In short, doctors seem to have to be hospital employees.

The Secretary did not believe this involved a matter within the call of the Special Session of the House, but did suggest that the Council might wish to record itself immediately in opposition to any such interpretation, and to make its view known in appropriate circles.

Doctors Bell–Dessloch moved that the Council record itself in opposition to this interpretation, and that the House of Delegates be fully informed on it at its next regular meeting.

Doctors Galasinski–Ekblad offered an amendment that a resolution be presented through the Wisconsin delegation at the next meeting of the American Medical Association.

The motion and amendment carried.

c. Statement on Costs of Current Controversy

In line with past action of the Council that costs of the current controversy not be borne by Blue Shield subscribers, the following statement was proposed for submission to the House:

"The costs of determining policy and procedure in the current administrative problems with Blue Cross–HIC–Surgical Care have not been inconsiderable.

"Special meetings of the Council, the Commission on Medical Care Plans, and of this House have been necessitated. Consultants have been retained. Staff overtime, travel and other costs have been incurred.

"The Council believes that these costs are properly those of the Society and should not in any part be borne by subscribers to Wisconsin Physicians Service. These individuals have paid their premiums to secure the benefits of the plan, not to contribute to the financing of interplan controversy of the character being considered by this House.

"The council has, therefore, directed these costs to be charged dues and related income. It has also directed the Society's independent certified public accountants to review all internal accounting procedures to that end and to provide a special report for consideration by the delegates in May of 1959."

On motion of Doctors Bell–Hill, carried, this statement was adopted.

d. Statement of policy

The following statement of policy was offered for consideration of the Council and possible submission to the House of Delegates:

"In prior years this Society, acting through the House of Delegates, has both approved Blue Cross of Wisconsin and commended it for successful promotion of hospital costs protection.

"At the present time the State Medical Society of Wisconsin, much against its wishes and its intent, finds itself in public debate with Blue Cross, with Health Insurance Corporation, its stock-for-profit insurance company, and with its activity in promoting a county society plan competitive to Wisconsin Physicians Service but using the same trade name and symbol of 'Blue Shield.'

"It was the earnest desire and active endeavor of the State Medical Society to avoid these developments. It felt that its plan, Wisconsin Physicians Service, and Blue Cross could stand in public association without requiring either to be subject to domination or control by, or necessarily under contract with, the other.

"It is fruitless now to recount all the details which led to administrative parting of the ways between the State Medical Society of Wisconsin and Blue Cross. The Society had developed a new program, the Special Service contract, which required field and sales servicing of a character which Blue Cross, in the Society's judgment, was unable to supply. The Society therefore proposed its own servicing staff, with certain internal operations delegated to Blue Cross.

"Late in 1956, Blue Cross had initiated a demand for an increased rate of compensation from the State Medical Society which the Society felt uneconomical and unreasonable. It was the inherent right of the State Medical Society, as the owner and operator of Wisconsin Physicians Service, to deny that request which, while subsequently lowered, was never withdrawn by Blue Cross.

"This impasse led to ultimate administrative separation of the plans. This was a mutual responsibility and not, as some Blue Cross personnel have said, solely a responsibility of the State Medical Society of Wisconsin.

"It was likewise the sincere endeavor of the State Medical Society to avoid these developments. But they came about.

"Consistent with the Society's position that both plans could stand in public association, the House of Delegates in May, 1958, adopted a resolution seeking just that, and inviting the hospitals of Wisconsin to cooperate to that end.

"Within a few days, however, Blue Cross of Wisconsin, a nonprofit organization, rejected this invitation and put into operation a stock-for-profit insurance company, solely owned and controlled by it, to engage in the sale of surgical-medical policies.

"Apparently in fear that the Blue Cross insurance company threatened the existence of its plan, Surgical Care, (although it had assurances to the contrary from Blue Cross,) The Medical Society of Milwaukee County, by action of its board of directors, first entered into ten counties which it considered part of metropolitan Milwaukee, and then, shortly afterwards, entered into the entire state. These are regrettable circumstances. Domination and fear were judgment considerations rather than public welfare, reason, and diplomacy.

"The State Medical Society of Wisconsin—faced with the fact that Blue Cross–Surgical Care–HIC were endeavoring to switch installations of the State Medical Society to their several programs, and in the process were attacking the adequacy and stability of the plan of the State Medical Society—had no alternative but to establish its own hospital costs protection.

"In doing so, it endeavored to create a 'contribution' to this field, as well as a contract. It believes it has done just that. Its program is related to the costs of hospitalization in the various areas of the state and does not blend metropolitan costs with those of rural areas.

"We deeply regret the circumstances forced upon us by the Blue Cross–Surgical Care–HIC alliance.

"Segments of the public perhaps will now consider the State Medical Society in opposition to the principal objectives of Blue Cross, when the fact is that the State Medical Society endorses the principle of free enterprise and, in common with the American Medical Association, asserts that 'The Voluntary Way is the American Way.'

"This position precludes the endorsement of but one approach to insuring against the costs of illness.

"We are at odds with Blue Cross–Surgical Care–HIC on administrative and interplan philosophy.

"We favor adequate insurance against the costs of illness, which should be their principal objective, rather than their current efforts to destroy the programs of the State Medical Society in pursuit of the same objective.

"Our major concern is not size, but sufficient freedom and opportunity for the State Medical Society to continue its well-established leadership in this movement.

"Despite the brazen unfairness, which should be terminated once and for all, of a county medical society joining in an effort to discredit and destroy the State Medical Society plan, and despite the most amoral of competitive approaches on the part of both Milwaukee plans in turning physician against physician, we can now report to the House of Delegates that the tide is turning.

"As it must be clear to all reasonable men, the ultimate issue is one of moral courage and of responsible conduct, and with the conviction that right grows out of justice and not out of financial might, your Council stands firm in its conclusion that WISCONSIN PHYSICIANS SERVICE will continue in this state and among all plans as one conceived with the best interests of the people at heart.

"We subscribe again to the statement . . .

'GIVE LIGHT AND THE PEOPLE WILL FIND THE WAY.'"

Following discussion, on motion of Doctors Garrison–Lokvam, carried, the statement was adopted and forwarded to the House; Doctors Bernhart, Conway, Galasinski, and Kilkenny voted in the negative.

7. Adjournment

The Council adjourned at 10:15 a.m. on September, 27, 1958.

C. H. Crownhart,
Secretary

Approved:
R. G. Arveson, M.D.,
Chairman of the Council

Attendance at House of Delegates

Special Session, September 27 and 28, 1958

Society	*Sessions* 1	2	3
Ashland–Bayfield–Iron—			
Delegate			
J. W. Prentice, Ashland	x	x	x
Alternate			
J. M. Jauquet, Ashland	x	x	x
Barron–Washburn–Sawyer–Burnett—			
H. M. Templeton, Barron	x	x	x
W. B. Rydell, Rice Lake	x	x	x
Brown—			
L. C. Miller, Green Bay	x	x	x
J. L. Ford, Green Bay	o	o	o
R. M. Waldkirch, DePere	x	x	x
S. L. Griggs, Green Bay	o	o	o
Calumet—			
J. A. Knauf, Stockbridge	o	o	o
A. C. Engel, New Holstein	o	o	o
Chippewa—			
J. J. Sazama, Chippewa Falls	o	o	o
C. A. Kemper, Chippewa Falls	o	o	o
Clark—			
M. V. Overman, Neillsville	x	x	x
J. W. Koch, Colby	o	o	o
Columbia–Marquette–Adams—			
R. F. Inman, Montello	x	x	x
R. T. Cooney, Portage	x	x	x
Crawford—			
V. C. Epley, Prairie du Chien	o	o	o
T. F. Farrell, Prairie du Chien	o	o	o
E. M. Dessloch, Prairie du Chien	x	x	x
Dane—			
J. R. Steeper, Madison	x	x	x
R. A. Straughn, Madison	x	x	x
M. T. Morrison, Mount Horeb	x	x	x
V. W. Nordholm, Stoughton	o	o	o
R. S. Gearhart, Madison	x	x	x
J. F. Land, Madison	o	o	o
C. W. Stoops, Madison	x	x	x
R. P. Sinaiko, Madison	o	o	o
G. C. Hank, Madison	x	x	x
R. J. Hennen, Madison	o	o	o
E. J. Nordby, Madison	x	x	x
H. M. Suckle, Madison	o	o	o
P. B. Golden, Madison	x	x	x
A. P. Schoenenberger, Madison	o	o	o
Dodge —			
L. W. Schrank, Waupun	x	x	x
H. G. Bayley, Beaver Dam	x	x	x
Door–Kawaunee—			
J. G. Beck, Sturgeon Bay	x	x	x
C. W. Stiehl, Algoma	o	o	o
Douglas—			
C. J. Picard, Superior	x	x	x
H. A. Sincock, Superior	o	o	o
Eau Claire–Dunn–Pepin—			
R. M. Lotz, Eau Claire	o	o	o
I. L. Blose, Durand	x	x	x
O. G. Moland, Augusta	x	x	x
R. C. Brown, Eau Claire	o	o	o
Fond du Lac—			
D. J. Twohig, Jr., Fond du Lac	x	x	x
R. S. Pelton, Ripon	x	x	x
Forest—			
E. F. Castaldo, Laona	o	o	o
B. S. Rathert, Crandon	x	x	x
Grant—			
E. C. Howell, Fennimore	o	o	o
M. W. Randall, Boscobel	o	o	o
H. W. Carey, Lancaster	x	x	x
Green—			
R. G. Zach, Monroe	o	o	o
W. E. Hein, Brodhead	x	o	x
Green Lake–Waushara—			
V. J. Taugher, Berlin	x	x	x
R. D. Wichmann, Wild Rose	o	o	o
Iowa—			
W. P. Hamilton, Dodgeville	x	x	x
W. D. Hamlin, Mineral Point	o	o	o
Jefferson—			
R. W. Quandt, Jefferson	x	x	x
H. G. E. Mallow, Fort Atkinson	x	x	x
Juneau—			
V. M. Griffin, Mauston	o	o	o
J. H. Vedner, Mauston	o	o	o
Kenosha—			
H. L. Schwartz, Kenosha	x	x	x
R. W. Ashley, Kenosha	o	o	o
La Crosse—			
J. J. Satory, La Crosse	x	x	x
E. L. Perry, La Crosse	o	o	o
J. P. McCann, La Crosse	x	x	x
J. R. Richter, La Crosse	o	o	o
Lafayette—			
L. L. Olson, Darlington	o	o	o
D. J. Garland, Shullsburg	o	o	o
Langlade—			
B. W. Beattie, Antigo	o	o	o
W. P. Curran, Antigo	x	o	o
Lincoln—			
D. F. Jarvis, Tomahawk	x	x	x
W. E. Braun, Merrill	o	o	o

	Sessions		
Manitowoc—			
W. E. Acheson, Valders	x	x	x
N. A. Bonner, Manitowoc	o	o	o
Marathon—			
D. M. Green, Wausau	x	x	x
E. P. Ludwig, Wausau	o	o	x
Marinette–Florence—			
C. E. Koepp, Marinette	o	o	o
J. W. Boren, Jr., Marinette	x	x	x
Milwaukee —			
F. A. Ross, Milwaukee	x	x	x
B. J. Brewer, Milwaukee	o	o	o
H. C. High, Jr., Milwaukee (see specialty section)			
R. T. McCarty, Milwaukee	o	o	o
D. W. Calvy, Milwaukee	o	o	o
R. F. Purtell, Milwaukee	x	x	x
J. J. O'Hara, Milwaukee	o	o	o
S. L. Chojnacki, Milwaukee	x	x	x
C. M. Schroeder, Milwaukee	x	x	x
A. J. Sanfelippo, Milwaukee	x	x	x
E. A. Habeck, Milwaukee	o	o	o
M. C. F. Lindert, Milwaukee	o	o	o
V. L. Baker, Milwaukee	x	x	x
D. M. Willson, Milwaukee	x	x	x
S. E. Zawodny, Milwaukee	o	o	o
E. M. End, Wauwatosa	x	x	o
H. F. Twelmeyer, Milwaukee	o	o	o
S. W. Hollenbeck, Milwaukee	x	x	x
P. F. Hausmann, Milwaukee	o	o	o
P. E. Oberbreckling, Milwaukee	x	x	x
A. A. Presti, Milwaukee	o	o	o
F. E. Drew, Milwaukee	x	x	x
R. E. Callan, Milwaukee	o	o	o
W. J. Houghton, Milwaukee	x	x	x
G. J. Bergmann, Milwaukee	o	o	o
G. W. Hilliard, Jr., Milwaukee	x	x	x
W. J. Conen, Milwaukee	o	o	o
J. F. Cary, Milwaukee	o	o	o
E. J. Schmidt, Milwaukee	x	x	x
J. M. Sullivan, Milwaukee	x	x	x
R. H. Lillie, Milwaukee	o	o	o
R. W. Mann, Milwaukee	o	o	o
D. M. Ruch, Milwaukee	x	x	x
H. J. Lee, Milwaukee	x	x	x
J. M. Beffel, Milwaukee	o	o	o
G. E. Collentine, Milwaukee	x	x	x
R. A. Nimz, Milwaukee	o	o	o
E. G. Collins, West Allis	x	x	x
R. H. Frederick, West Allis	o	o	o
N. J. Wegmann, Milwaukee	o	o	o
W. L. Coffey, Milwaukee	x	x	x
Monroe—			
D. C. Beebe, Sparta	x	x	x
J. S. Allen, Norwalk	x	x	x
Oconto—			
H. A. Aageson, Oconto	o	o	o
G. R. Sandgren, Suring	x	x	x
Oneida–Vilas—			
Marvin Wright, Rhinelander	o	o	o
I. E. Schiek, Rhinelander	o	o	o

	Sessions		
Outagamie—			
G. W. Carlson, Appleton	x	x	x
H. T. Gross, Appleton	o	o	o
Pierce–St. Croix—			
P. H. Gutzler, River Falls	x	x	x
O. H. Epley, New Richmond	o	o	o
Polk—			
L. O. Simenstad, Osceola	x	x	x
R. M. Moore, Frederic	o	o	o
Portage—			
F. E. Gehin, Stevens Point	x	x	x
R. H. Slater, Stevens Point	o	o	o
Price–Taylor—			
J. D. Leahy, Park Falls	x	x	x
W. E. Niebauer, Phillips	o	o	o
Racine—			
Gordon Schulz, Union Grove	x	x	x
F. J. Scheible, Racine	o	o	o
R. W. Kreul, Racine	x	x	x
L. E. Fazen, Jr., Racine	o	o	o
Richland—			
R. E. Housner, Richland Center	x	x	x
D. J. Taft, Richland Center	x	x	x
Rock—			
W. S. Freeman, Beloit	x	x	x
C. M. Carney, Beloit	o	o	o
M. D. Davis, Milton	x	x	x
H. M. Snodgrass, Janesville	o	o	o
Rusk—			
H. F. Pagel, Ladysmith	o	o	o
J. E. Murphy, Ladysmith	o	o	o
M. L. Whalen, Bruce	o	x	x
Sauk—			
C. R. Pearson, Baraboo	x	x	x
J. J. Rouse, Reedsburg	o	o	o
Shawano—			
H. C. Marsh, Shawano	o	o	o
D. A. Jeffries, Shawano	x	x	x
Sheboygan—			
P. B. Mason, Sheboygan	x	x	x
F. A. Nause, Sheboygan	o	o	o
Trempealeau–Jackson–Buffalo—			
B. C. Dockendorff, Arcadia	x	x	x
E. P. Rohde, Galesville	o	o	o
Vernon—			
T. E. Boston, Hillsboro	x	x	x
P. T. Bland, Westby	o	o	o
Walworth—			
E. D. Sorenson, Elkhorn	x	x	x
E. D. Hudson, Lake Geneva	o	o	o
Washington–Ozaukee—			
P. B. Blanchard, Cedarburg	x	x	x
W. A. Nielsen, West Bend	x	x	o
Waukesha—			
Joseph Bartos, Waukesha	o	o	o
Aaron Sweed, Waukesha	o	o	o
J. V. Bolger, Jr., Waukesha	x	x	x
Waupaca—			
M. O. Boudry, Waupaca	o	o	o
W. R. McInnis, Marion	o	o	o
O. E. Larson, Clintonville	x	o	o

Winnebago—

George Schwei, Menasha	x	x	x
David Regan, Neenah	o	o	o
E. A. Strakosch, Oshkosh	x	x	x
W. V. Hahn, Oshkosh	o	o	o

Wood—

R. W. Mason, Marshfield	x	x	x
E. C. Glenn, Wisconsin Rapids	x	x	x

Section

General Practice—

A. H. Stahmer, Wausau	o	o	o
D. N. Goldstein, Kenosha	x	x	x

Internal Medicine—

L. J. Kurten, Racine	o	o	o
R. L. Gilbert, La Crosse	o	o	o

Neurology and Psychiatry—

R. A. Jefferson, Milwaukee	x	o	o

Obstetrics and Gynecology—

Elizabeth Steffen, Racine	o	o	o
R. T. Flynn, Milwaukee	o	o	o

Ophthalmology and Otolaryngology—

H. C. High, Jr., Milwaukee	x	x	x
George Nadeau, Green Bay	x	o	o

Orthopedics—

P. K. Odland, Janesville	o	o	o
M. W. Nelson, Racine	o	o	o

Pathology—

Gorton Ritchie, Milwaukee	x	x	x
E. A. Birge, Milwaukee	o	o	o

Pediatrics—

S. E. Kohn, Milwaukee	o	o	o
J. R. Schroder, Janesville	o	o	o

Public Health—

C. K. Kincaid, Madison	o	o	o
E. E. Bertolaet, West Allis	o	o	o

Radiology—

W. T. Clark, Janesville	x	x	x
F. F. Golden, Madison	o	x	x

Surgery—

G. N. Gillett, Racine	o	o	o
John Conway, Milwaukee	x	x	x

Urology—

J. W. Sargent, Milwaukee	x	x	x
R. S. Irwin, Milwaukee	o	o	o

Please Doctor!

Each month there are a number of journals returned to the office because of a change of address which was not brought to the attention of the staff. Postage is paid for these returned journals, and additional postage paid again when sending them to the new address. It would be of much help and less expense if the Journal could be notified of these address changes at least six weeks in advance. Your cooperation will be greatly appreciated. Below is a form for your convenience.

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SEPTEMBER 27-28, 1958

Hardware Mutuals Insurance Company Auditorium

STEVENS POINT, WISCONSIN

TRANSACTIONS OF THE SPECIAL SESSION, HOUSE OE DELEGATES, STATE MEDICAL SOCIETY OF WISCONSIN

September 27–28, 1958, Stevens Point

SATURDAY MORNING SESSION

September 27, 1958

The first session of the Special Session of the House of Delegates of the State Medical Society of Wisconsin convened at ten thirty-five o'clock in the Auditorium of the Hardware Mutuals Insurance Company building, Stevens Point, Wisconsin, with Dr. J. D. Leahy, Speaker of the House, presiding.

Speaker Leahy: Gentlemen, we are about to call the meeting of the Special Session of the House of Delegates to order.

It is nice to see such a good turnout here representing all the districts throughout the state, and we will not take up any time with a speech on the part of the Speaker.

There will probably be plenty of speeches here today. We will have a report from the Credentials Committee, which is made up of our Vice Speaker, Lokvam, and Drs. L. W. Schrank and B. W. Beatty.

Vice Speaker Lokvam: Mr. Speaker, the Credentials Committee reports the following registered delegates and alternate delegates for the first session of the House of Delegates.

Registration of 59 delegates and 16 alternate delegates.

Also, the Credentials Committee has been informed by the Secretary of the Grant County Medical Society of the appointment of H. W. Carey to act as delegate for that society in place of the regular delegate and alternate who are unable to attend.

In addition, 10 alternate delegates have registered their attendance.

Mr. Speaker, I move that the attendance roll of delegates, alternate delegates and specially appointed delegates, totalling 75 so compiled by the Credentials Committee, be accepted as the official roll of this session of the House to stand for the entire session.

May I correct that. I believe there have been two or three additional registrations since this roll.

Secretary C. H. Crownhart: They can come in with a supplementary report.

Speaker Leahy: You have heard the report. I will now entertain a motion that the report be accepted subject to the supplementary report.

Dr. E. D. Sorenson (Elkhorn): I so move.

Dr. Gordon Schulz (Union Grove): I second the motion.

Speaker Leahy: The motion has been made and seconded. Any discussion? All those in favor say "Aye"; contrary "Nay." The motion is carried.

Mr. Crownhart will explain this statement.

Secretary Crownhart: The Council has submitted to the members of the House a statement which it recommends for immediate consideration, namely that all sessions of the House as well as the session of the Reference Committee be conducted in open session, so that the press and others who are in attendance may feel free to listen in.

Dr. P. B. Mason (Sheboygan): I so move.

Dr. R. W. Kreul (Racine): I second the motion.

Speaker Leahy: Any discussion? All those in favor say "Aye"; contrary "No." Carried.

Dr. F. E. Drew (Milwaukee): Mr. Speaker, in keeping with the statement made by the Council on this open meeting, and I think all the men here are concerned about getting all the information that is available as rapidly as possible to facilitate handling it, I would like to make the following motion:

> I move that the assembly do now resolve itself into a committee of the whole to take under consideration the resolutions presented for consideration and adoption by this body.

Dr. J. M. Sullivan (Milwaukee): I second the motion.

Dr. E. J. Nordby (Madison): Mr. Speaker, I would like to ask a question as to this motion. What vote does it take to carry the motion? There are about four questions. I will enumerate them first.

What vote does it take to carry the motion to go into the committee of the whole? Two, what motions are in order while acting as a committee of the whole? Three, it is my understanding under the Roberts' Rules of Order the House must establish rules of order for the committee as a whole. I would feel we should have the same rules as the regular House of Delegates session, which would then include a five-minute limit for each speaker and a definite time for adjournment. I would suggest four p.m., and I request a roll call vote on the motion to go into the committee as a whole and a ten-minute recess before voting.

Secretary Crownhart: Gentlemen, for the record, it is imperative that we have the name of the person, where he is from, and so we would appreciate it if you would come to the rostrum as you make your statement.

Speaker Leahy: I will ask Mr. Crownhart to respond to this.

Secretary Crownhart: I don't pretend to have memorized Roberts' Rules of Order. However, the Speaker of the House some years ago ruled that the procedure required by the bylaws is the referral of business to a reference committee, and that the time the motion was made to go into the committee of the whole, at that time the Speaker ruled that it required suspension of the rules, and thus a two-thirds vote in the affirmative.

Doctor Nordby, you asked what rules govern the conduct of the committee, if it is in the committee of the whole. Is that correct?

Doctor Nordby (Madison): What motions are in order, yes; rules, too.

Secretary Crownhart: Well, perhaps it is easier to state some motions that aren't in order. It cannot adjourn. It must come to a conclusion, or if it fails to come to a conclusion when it arises from the committee of the whole, it states that its deliberations were without effect, and in practical effect the motion then would be it comes to no conclusion at all. Essentially a committee of the whole conducts itself as a reference committee, but the rules must be established by the assembly which creates the committee of the whole. The committee of the whole cannot refer to another committee. It cannot change the text of any resolutions submitted to it, but it can originate, as I understand it, a resolution within its own structure.

At the time the committee of the whole has concluded its deliberations, the motion is that it rise from the committee of the whole. Then it goes back into the assembly, and you listen to what you just did in the committee of the whole. That is the effect of it. That, in effect, according to Roberts' Rules of Order, is the motion to adjourn. In other words, the motion to rise from the committee of the whole is not debatable because it is in the character of a motion to adjourn. I don't know whether I got all your questions or not.

It does take a two-thirds vote. That is the precedent of the House.

Mr. Speaker, Doctor Nordby requested a ten-minute recess.

Speaker Leahy: You may have the recess at this time of ten minutes.

(A ten-minute recess was taken.)

Speaker Leahy: The Speaker at this time will recognize Mr. Crownhart to explain some details.

Secretary Crownhart: Mr. Speaker, I have noted that not all the business to be considered by the House is before the House as yet. There is a supplementary report of the Council, and there is a resolution from the Sixth Councilor District, and neither have rules been established. I have suggested to Doctor Drew, who made the motion, that the motion is not out of order, but it is premature by probably fifteen minutes, so that we can have all the business before the House. Otherwise, it won't be in. Whatever committee meets won't have a chance to deliberate on some of it, so I would suggest, Mr. Speaker, that Doctor Drew and his second consent to withholding the motion for approximately fifteen minutes or so.

Doctor Drew (Milwaukee): Mr. Speaker, I will accept that, to hold the vote until the business is all in.

Doctor Sullivan (Milwaukee): I will agree.

Speaker Leahy: Under the rules of order, the provision of Chapter 10 of the Bylaws says, the deliberations of this Society are governed by Roberts' Rules of Order. In addition, for a number of years this House has adopted certain standing rules and has accepted the Speaker's statement on the privilege of the floor. The procedural rules (taken from the Constitution and Bylaws), the standing rules adopted in previous sessions, and the tradition of the floor has been distributed to each delegate and others.

The Speaker will now entertain a motion that these rules be accepted as the rules governing this special session. Could I hear a motion?

Dr. M. V. Overman (Neillsville): I so move.

Dr. R. S. Gearhart (Madison): I second the motion.

Speaker Leahy: The motion has been made and duly seconded. Is there any discussion?

Dr. D. M. Willson (Milwaukee): Mr. Speaker, in a discussion of the subject as important as this one is, is it not more desirable that we have a little more time for debate and presentation of subjects on the floor than the customary five minutes limit previously incorporated in the rules?

I move to amend the rules as presented so that speakers may have a period of twelve minutes for discussion.

Speaker Leahy: The motion is in order.

Dr. A. J. Sanfelippo (Milwaukee): I second the motion.

Speaker Leahy: The motion has been made and seconded. Is there any discussion?

Dr. I. L. Blose (Durand): Point of order, it is already a motion. There is already a motion on the floor. Is that an amendment to the motion?

Speaker Leahy: It is in order.

That is an amendment to the motion.

Doctor Willson (Milwaukee): Mr. Speaker, on further discussion, I do not believe the standing rules of the House, our bylaws, have any precedent or represent any change. Each time this House is constituted as an organization that sets its rules. The rules which have been read are merely the customary rules of the past. We are not making

any change. We are just adopting a different type of rule as we set up this House.

Doctor Nordby (Madison): Mr. Speaker, does this include each individual one time for twelve minutes?

Doctor Willson (Milwaukee): May I answer. My interpretation would be we are changing the figure five to twelve in the third rule.

Doctor Nordby (Madison): My understanding is each one has an appearance for five minutes in the present rule. Is that correct?

Doctor Willson (Milwaukee): I do not know that.

Speaker Leahy: That is right. The vote now is on the amendment.

All those in favor of this signify by saying "Aye"; contrary. The amendment is carried.

Now we vote on the first motion as amended.

All those in favor of this signify by saying "Aye"; contrary. Carried.

The Council has recommended to the House the following special rules for this session. That material for consideration of the House be filed no later than its initial session, or before the Reference Committee. No material would then be received by the House at its second session.

Second, that the Reference Committee should permit those not associated with the medical profession to appear before it only by the committee's invitation.

The Speaker calls for a motion to that effect.

Dr. George Schwei (Menasha): I so move.

Dr. E. A. Strakosch (Oshkosh): I second the motion.

Speaker Leahy: Any discussion?

All those in favor signify by saying "Aye"; contrary. Carried.

In calling this special session the Council stated that it shall be for the "express purpose of complete information and study of the philosophy and policies of prepaid medical care programs in Wisconsin."

Meeting subsequently, the Executive Committee of the Council concluded that the call related to Wisconsin Physicians Service operated by the State Medical Society and the prepaid plan operated by The Medical Society of Milwaukee County known as Surgical Care. The Executive Committee also agreed that the call relates to the hospital service plan of Associated Hospital Service, Inc. of Milwaukee (Blue Cross) and the programs of its stock insurance company, Health Insurance Corporation of Milwaukee.

The committee agreed further that the call of the House permitted action by it.

The Speaker agrees and so rules.

The Secretary's Special Report No. 14 constitutes the report of the Council. In that report is contained among other matters:

> *First:* A recommendation that the Council will conduct a study of insurance laws with the purpose of recommending to the 1959 Legislature minimal supervisory powers in the Insurance Commissioner over the so-called "Blue" plans.

The Speaker declares this recommendation properly before this Special Session.

> *Second:* A recommendation that the Council will constitute a special study of hospital insurance in Wisconsin.

The Speaker declares this recommendation properly before this Special Session of the House.

> *Third:* The Council recommends that every county medical society so amend its bylaws as to assure that it will conduct no functioning operation within the territorial jurisdiction of another county society unless with the formal consent of that society and with the approval of the State Medical Society.

The Speaker declares this recommendation properly before the House in this Special Session.

> *Fourth:* A Council statement relative to the use of the term and symbol "Blue Shield" by The Medical Society of Milwaukee County in areas other than Milwaukee County.

The Speaker declares this recommendation properly before this Special Session.

> *Fifth:* A statement by the Council relative to its interest to call meetings of the House at times other than the annual meeting.

This is a matter of procedure and the Speaker declares it properly reportable to the House at this session.

The Secretary's Special Report No. 3 transmits to the House two resolutions submitted by component county medical societies.

The first resolution is by The Medical Society of Milwaukee County. It proposes a management study of the State Medical Society. The Speaker takes notice of the comment of the Council concerning that resolution, contained in Special Report No. 14. The Speaker agrees with that statement and rules that the resolution is not germane to the call of the House.

Doctor Sullivan (Milwaukee): Point of order on whether the Speaker has the authority to make this ruling. It is our contention that at the last meeting of the House of Delegates the primary purpose of introducing Resolution No. 8 was to study the structure of the State Medical Society. We think this is germane to the present meeting. This thing was killed in Reference Committee at the last meeting; and if we rule this resolution out, we from Milwaukee feel that we haven't put the thing across to you.

Now, why is there any objection to our just looking over our own structure? What is the matter? If we do look over our own structure, we can find probably where we can improve it, and all this controversy may be settled, proving probably Milwaukee is wrong in instances or proving delegates from other sections are wrong. But we must have the facts about our own structure. There have been so many controversial statements made that we feel the Speaker does not have the right to rule this resolution out, and we appeal for a vote from the floor.

Speaker Leahy: The motion has not been seconded as yet.

Dr. G. E. Collentine (Milwaukee): Mr. Speaker, I second Doctor Sullivan's motion that the subject of Resolution No. 8 be considered by the House at this time.

Dr. J. P. McCann (La Crosse): Mr. Chairman, if that was a motion he made, I was out of order. I was going to make the motion to appeal the Speaker's ruling. I didn't understand it as a motion. I am sorry.

Speaker Leahy: Is there any discussion?

Dr. G. W. Carlson (Appleton): Mr. Speaker, will you give that of part eight so we can understand it?

Secretary Crownhart: I don't think either the Speaker or the Secretary understand you, Doctor Carlson.

Doctor Carlson (Appleton): I want to know what this motion is?

Secretary Crownhart: The Speaker, according to the Seretary's notes, has affirmed the recommendation of the Council that the resolution introduced by Milwaukee County is not germane to this session as was reported in Special Report No. 14. Doctor Sullivan has appealed from the decision of the Chair, and the question before the House now is whether the ruling of the Chair shall be sustained.

Dr. C. W. Stoops (Madison): Mr. Speaker, can we have a roll call on this?

Dr. R. E. Galasinski (Milwaukee): Mr. Chairman, can we have someone read Resolution No. 8, please?

Speaker Leahy: Is there any object in having this read? Everybody has a copy of it.

Dr. W. J. Houghton (Milwaukee). It is germane, and if you read it, you will see it is germane. We want it read.

Dr. J. G. Beck (Sturgeon Bay): I think we all know what the resolution is. I see no reason in having it read at this time.

I make a motion we dispense with the reading of this resolution.

Doctor Kreul (Racine): Mr. Speaker, may I have a rereading of the remarks made by Doctor Sullivan because I don't believe that was in the form of a motion. I think it was in the form of a point of order, so there is no motion before the House at the present time.

Doctor Sullivan (Milwaukee): Mr. Speaker, that is correct. I so move. That is in the form of a motion. I intend that to be presented to the House as a motion.

Speaker Leahy: As a motion, and it was seconded as a motion.

Are you ready for the question?

Secretary Crownhart: I think the request, Mr. Speaker, is in order under Roberts' Rules of Order. If any member of the assembly wishes a resolution or other material before it read to the assembly, he has the right to make that request, so long as his motion is on the basis of information, according to Roberts' Rules of Order.

I will read this paragraph which I think applies. It is on page 102 of Roberts' Rules of Order, if you have it. "Where papers are laid before the assembly, every member has a right to have them read once, or if there is debate or amendment, he has the right to have them read again before he can be compelled to vote on them. Whenever a member asks for the reading of any such paper evidently for information and not for delay, the Chair should direct it to be read if no one objects, but a member has not the right to have anything read excepting as stated above without permission of the assembly."

There is more, but I believe that is the pertinent portion. They are entitled to have the resolution read unless there is objection from the assembly.

Speaker Leahy: We will read the Resolution No. 8.

Secretary Crownhart: Letter received by me in April, letter dated April 10.

Doctor Collentine (Milwaukee): Mr. Speaker, I believe since the Chair has ruled that the resolution submitted recently by the Milwaukee County delegation is not germane, it should be the complete resolution submitted thirty days before the meeting of this House that should be read at this time.

Secretary Crownhart: You are correct, Doctor Collentine.

Letter dated August 25 and in Special Report No. 3.

> The following resolution is submitted to you within the thirty day time limit for presentation to the forthcoming special meeting of the House of Delegates to be held at Stevens Point on September 27–28, 1958.
>
> WHEREAS the Milwaukee Delegates to the State Medical Society of Wisconsin are fully aware of the events developing since the last Annual Meeting of the State Medical Society, particularly with regard to the difficulties that have arisen in the operations of the prepaid medical care plans, the institution of Health Insurance Corporation, and the selling of Milwaukee Surgical Care throughout the state of Wisconsin in conjunction with Blue Cross, and
>
> WHEREAS the Milwaukee Delegates have carefully considered their position and future course of action, and

WHEREAS there is a strong desire among all of the Delegates of the State Medical Society for the avoidance of conflict and for the continuation of the cordial relationship among all the doctors of the state, and

WHEREAS this cordial association is deemed absolutely necessary, and

WHEREAS there has been no change in the basic convictions of the Delegates from Milwaukee County, and

WHEREAS the health and welfare of the people of the state of Wisconsin is and should be the primary concern of all physicians, and

WHEREAS a unanimity of action among the physicians of the state of Wisconsin is highly desirable to the successful treatment and care of the people,

THEREFORE, BE IT RESOLVED and deemed mandatory that the attached resolution for the study of the State Medical Society and departments as presented as Resolution No. 8 at the Annual Meeting of the State Medical Society in May, 1958, by the Delegates from Milwaukee County be adopted by the House of Delegates.

WHEREAS the Milwaukee Delegates to the State Medical Society have expressed much concern over the separation of Wisconsin Blue Cross and Wisconsin Physicians Service and;

WHEREAS a special committee has been appointed and has studied all the available facts surrounding the separation of Wisconsin Blue Cross and Wisconsin Physicians Service and;

WHEREAS this change involves patient care in Wisconsin and;

WHEREAS there is also much concern of the decision to separate Wisconsin Physicians Service and Wisconsin Blue Cross inasmuch as the action occurred immediately following the adjournment of the House of Delegates and was never referred to the House and;

WHEREAS ostensibly the matter was considered by the Council only and the Council then delegated any action regarding this matter to the Commission on Medical Care Plans for action and;

WHEREAS it is believed that this decision was too important for Commission action and an action which should have been brought before the House of Delegates according to the Constitution of the State Medical Society (Article V) and;

WHEREAS at no time were the members of the State Medical Society of the State of Wisconsin notified that this important issue was being discussed;

THEREFORE, BE IT RESOLVED that the House of Delegates of the State Medical Society be requested to appoint a five-man committee, to be composed of two Milwaukee Delegates and three Delegates from elsewhere in the state, and containing no present nor past officers nor councilors of the Society, to conduct a thorough study of

(a) the structure, function, and duties of the Council, including duties delegated

(b) the structure and duties of the House of Delegates

(c) the structure and duties of the staff of the State Medical Society and to whom they are responsible, both for routine and policy decisions

(d) the operation of Wisconsin Physicians Service as it affects the health picture, public relations between the public and the medical profession, and as it affects relationships within the medical profession;

IT IS FURTHER RESOLVED that consideration be given to studying the Constitution of the State Medical Society, which was adopted many years ago and may not now be the most workable for the Society in carrying on its present day activities and;

IT IS FURTHER RESOLVED that to assist and advise this committee, a suitable firm of management engineers, consultants, or specialists in medical association administration, organizational bodies, bylaws and procedures be retained and made available;

IT IS FURTHER RESOLVED that the sum of $10,000 be appropriated to initiate this study.

Sincerely yours,
D. M. WILLSON, M.D.
Chairman, Milwaukee Delegation

Speaker Leahy: Is there any further discussion? (The question was called for.)

Speaker Leahy: A roll call has been requested.

Secretary Crownhart: Are there any delegates who have entered the room without registration at the credentials desk? If there are, they should immediately register so their names can be called. I have everything here but the roll call.

Dr. J. W. Prentice (Ashland): Mr. Speaker, what are we voting on now?

Speaker Leahy: You are voting on this resolution that was brought in. You are voting on Doctor Sullivan's motion that this would be accepted.

Doctor Prentice (Ashland): Are we voting that it be accepted or that it is germane?

Secretary Crownhart: The motion before the House is to appeal from the decision of the Speaker that the resolution as submitted from Milwaukee County is not germane to the call of the House. The question to be stated is: Shall the decision of the Chair stand as the judgment of the Society? In other words, shall the decision of Doctor Leahy be sustained by this assembly?

Doctor Strakosch (Oshkosh): Mr. Speaker, the query, the resolution has been brought before the House and was defeated. Can it be re-introduced in the same session without the unanimous consent of the House?

Speaker Leahy: Majority vote.

Doctor Sullivan (Milwaukee): Mr. Speaker, we feel this is not the same session of the House of Delegates. We also feel that we can bring up this motion at any time. If we are going to be hog-tied by a parliamentary rule here, why I don't know what is going to happen. I would like to suggest before we put this thing to a vote that we hear from a member of the Council as to why they feel this motion is not germane.

Doctor Strakosch (Oshkosh): Point of order, Mr. Speaker. I have not gotten an answer to the question before Doctor Sullivan raised the next question.

I am still waiting for the answer to my question before Doctor Sullivan gets his question answered. In other words, I would like to have a ruling by the Chair. I will restate the question, Mr. Speaker.

Speaker Leahy: To sustain the Speaker.

Secretary Crownhart: He asked the question from the floor. Doctor, as I understand it, Doctor Strakosch has a question to ask which has not been answered, and I am quite certain that is true because everybody was talking all at once there. Now he has asked for an opportunity to restate his question.

Doctor Strakosch (Oshkosh): The question is, since the resolution of the Milwaukee County Medical Society has already been voted down in the last session which is still the same here, can it be re-introduced in this year without the unanimous consent of the House?

Secretary Crownhart: Mr. Speaker, it is not the desire of the Secretary to confuse this session of the House either. There was distributed in Special Report No. 14 the recommendations of the Council. The Council took action upon the resolution of The Medical Society of Milwaukee County to the following effect: It stated its conclusion that it is, number one, not germane to the call of the Special Session. Number two, the Council reports that the House of Delegates in May 1958 acted upon the subject, and it cannot now be re-introduced even if in order except by reconsideration of House action in May. And number three, the Council stated in substance that it is already at work upon the matter as a result of the action taken in May.

That is in Special Report No. 14 on the green pages.

Doctor Willson (Milwaukee): Mr. Speaker, may I point out to the assembly Article VI of the Constitution and Bylaws of the State Medical Society of Wisconsin. The Council shall be the Board of Trustees of this Society and have full authority and power of the House of Delegates between annual sessions unless the House of Delegates shall be called into session as provided by the Constitution and Bylaws.

I think your interpretation of that is that this House is now in session, and it has the power to approve the action of the Council, that there is a stratification of power within the Society.

The supreme power of the Society is the individual members, and the next group in power is this House of Delegates. In the interval between, when this House is not in session, it is the Council, and presumably in the interval without the Council, it is the Executive Committee, and beyond that it is the province of the administration in decreasing order—I say decreasing order of authority. Therefore, it is our opinion that this is a matter which is subject solely to the will of this assembled body. Thank you.

Speaker Leahy: The question is whether this can be re-introduced. It can be re-introduced at this session, and we have that motion of Doctor Sullivan and all that takes is a majority vote as I see it.

Dr. E. M. Dessloch (Prairie du Chien): Mr. Speaker, I would then ask that the Reference Committee's report as adopted by the last House also be read. I request it.

Doctor Willson (Milwaukee): Is that germane to the resolution being submitted by Milwaukee?

Speaker Leahy: Will you give the report on that, please?

Dr. E. D. Sorenson (Elkhorn): Gentlemen, I was on the Resolutions Committee, chairman of the committee, this past session. I have before me the report to the House which was adopted at that session of the House, and I shall read it as I gave it to you before.

> "And now we come to the Resolutions Nos. 8 through 12. The committee has been impressed with the sincerity and motivation of all concerned in the presentations which it heard this morning. The committee wishes to recommend that Resolution No. 8 be rejected, but that the Council consider the desirability of authorizing and implementing such a study; the results of which would be presented to the delegates and the members of the Society. In view of this recommendation, we also recommend that Resolutions Nos. 9, 10, 11 and 12 be rejected."

Mr. Speaker, I am wondering in view of that report, if the report of the Resolutions Committee at the last regular meeting must be repudiated by the House before it can be introduced again.

Speaker Leahy: Before that, we will have our credentials report. There are a few additions.

Vice Speaker Lokvam: Mr. Speaker, in addition to those delegates already registered and reported by the Committee on Credentials, four delegates and

four alternate delegates have registered and are entitled to vote.

Also, the Credentials Committee has been informed by the Secretary of the Crawford Medical Society of the appointment of E. M. Dessloch to act as delegate for that Society in place of the regular delegate and alternate who are unable to attend.

Also, the Credentials Committee has been informed by the Secretary of the Waukesha County Medical Society of the appointment of J. V. Bolger, Jr., to act as delegate for that Society in place of the regu'ar delegate and alternate delegate who are unable to attend.

In addition, two alternate delegates, seven councilors, and four officers have registered their attendance.

Mr. Speaker, I now move that the attendance roll of delegates, alternate delegates and specially appointed delegates, totalling eighty-three so compiled by the Credentials Committee be accepted as the official roll of this session of the House to stand for the entire session.

Dr. E. D. Sorenson (Elkhorn): I second the motion.

Secretary Crownhart: The Secretary understands the question before the House is an appeal from the decision of the Chair. The question then, according to Roberts' Rules of Order, is: Shall the decision of the Chair be sustained? Those who agree with the decision of the Chair will vote "Aye"; those who disagree will vote "No."

Doctor Prentice (Ashland): What was the decision of the Chair?

Secretary Crownhart: The decision of the Chair was to agree with the decision of the Council, namely, that the Milwaukee resolution was not germane and not subject to re-introduction at this session.

(Secretary Crownhart called the roll which was answered as follows:)

Dr. J. W. PRENTICE (Ashland): I vote "No."
Dr. H. M. TEMPLETON (Barron): No.
Dr. L. C. MILLER (Green Bay): No.
Dr. R. M. WALDKIRCH (De Pere): No.
Dr. E. A. STRAKOSCH (Oshkosh): Point of order.
Dr. M. V. OVERMAN (Neillsville). No.
Dr. R. S. INMAN (Montello): Yes.
Dr. E. M. DESSLOCH (Prairie du Chien): Yes.
Dr. J. R. STEEPER (Madison) Yes.

Dr. M. V. Overman (Neillsville): I wish to agree with the Chair, and to do that I vote "No"? Is that correct?

Secretary Crownhart: At the conclusion of a roll call and before the vote is announced, any delegate may ask that his vote be changed.

Doctor Strakosch (Oshkosh): Will you restate the issue?

Secretary Crownhart: If you vote "Yes," you vote in favor of the decision of the Chair.

Doctor Drew (Milwaukee): Mr. Speaker, I wish there would be no interruptions to the roll call, please.

(Secretary Crownhart continued calling the roll which was answered as follows:)

Dr. M. T. MORRISON (Mount Horeb): Yes.
Dr. R. S. GEARHART (Madison): Yes.
Dr. O. W. STOOPS (Madison): Yes.
Dr. G. C. HANK (Madison): Yes.
Dr. E. J. NORDBY (Madison): Yes.
Dr. P. B. GOLDEN (Madison): Yes.
Dr. L. W. SCHRANK (Waupun): Yes.
Dr. J. G. BECK (Sturgeon Bay): Yes.
Dr. C. J. PICARD (Superior): Yes.
Dr. I. L. BLOSE (Durand): Yes.
Dr. O. G. MOLAND (Augusta): Yes.
Dr. D. J. TWOHIG, Jr. (Fond du Lac): Yes.
Dr. H. W. CAREY (Lancaster): Yes.
Dr. W. E. HEIN (Brodhead): Yes.
Dr. V. J. TAUGHER (Berlin): Yes.
Dr. W. P. HAMILTON (Dodgeville): Yes.
Dr. R. W. QUANDT (Jefferson): Yes.
Dr. H. L. SCHWARTZ (Kenosha): Yes.
Dr. J. J. SATORY (La Crosse): Yes.
Dr. J. P. McCANN (La Crosse): No.
Dr. W. P. CURRAN (Antigo): No.
Dr. D. F. JARVIS (Tomahawk): No.
Dr. W. E. ACHESON (Valders): No.
Dr. D. M. GREEN (Wausau): Yes.
Dr. J. W. BOREN, Jr. (Marinette): Yes.
Dr. F. A. ROSS (Milwaukee): No.
Dr. H. C. HIGH, Jr. (Milwaukee): — (voted as section delegate)
Dr. R. F. PURTELL (Milwaukee): No.
Dr. S. L. CHOJNACKI (Milwaukee): No.
Dr. A. J. SANFELIPPO (Milwaukee): No.
Dr. V. L. BAKER (Milwaukee): No.
Dr. D. M. WILLSON (Milwaukee): No.
Dr. E. M. END (Wauwatosa): No.
Dr. S. W. HOLLENBECK (Milwaukee): No.
Dr. P. E. OBERBRECKLING (Milwaukee): No.
Dr. F. E. DREW (Milwaukee): No.
Dr. W. J. HOUGHTON (Milwaukee): No.
Dr. G. W. HILLIARD, Jr. (Milwaukee): No.
Dr. E. J. SCHMIDT (Milwaukee): No.
Dr. J. M. SULLIVAN (Milwaukee): No.
Dr. D. M. RUCH (Milwaukee): No.
Dr. H. J. LEE (Milwaukee): No.
Dr. G. E. COLLENTINE (Milwaukee): No.
Dr. E. G. COLLINS (West Allis): No.
Dr. W. L. COFFEY (Milwaukee): No.
Dr. D. C. BEEBE (Sparta): Yes.
Dr. G. R. SANDGREN (Suring): Yes.
Dr. G. W. CARLSON (Appleton): Yes.
Dr. P. H. GUTZLER (River Falls): Yes.
Dr. L. O. SIMENSTAD (Osceola): Yes.
Dr. F. E. GEHIN (Stevens Point): Yes.
Dr. J. D. LEAHY (Park Falls): Yes.
Dr. GORDON SCHULZ (Union Grove): Yes.
Dr. R. W. KREUL (Racine): Yes.
Dr. R. E. HOUSNER (Richland Center): Yes.
Dr. W. S. FREEMAN (Beloit): No.
Dr. M. D. DAVIS (Milton): Yes.
Dr. C. R. PEARSON (Baraboo). Yes.
Dr. D. A. JEFFRIES (Shawano): Yes.
Dr. P. B. MASON (Sheboygan): Yes.
Dr. B. C. DOCKENDORFF (Arcadia): Yes.
Dr. T. E. BOSTON (Hillsboro): Yes.
Dr. E. D. SORENSON (Elkhorn): Yes.
Dr. W. A. NIELSEN (West Bend): Yes.
Dr. J. V. BOLGER, Jr. (Waukesha): No.
Dr. GEORGE SCHWEI (Menasha): Yes.
Dr. E. A. STRAKOSCH (Oshkosh): Yes.
Dr. R. W. MASON (Marshfield): Yes.
Dr. D. N. GOLDSTEIN (Kenosha, General Practice): — (absent or not voting)
Dr. R. A. JEFFERSON (Milwaukee, Neurology and Psychiatry): No.

Dr. H. C. HIGH, Jr. (Milwaukee, Ophthalmology and Otolaryngology): Mr. Secretary, I think that my name was called as a delegate, as a registered alternate from Milwaukee County. I am here as a delegate of the Section, not as a delegate from the county.
The vote is "No."

Secretary Crownhart: The Secretary reports Doctor High as voting "No," representing the Section on Ophthalmology and Otolaryngology.

(Secretary Crownhart continued calling the roll.)

Dr. GORTON RITCHIE (Milwaukee, Pathology): No.
Dr. W. T. CLARK (Janesville, Radiology): Yes.
Dr. JOHN CONWAY (Milwaukee, Surgery): No.
Dr. J. W. SARGENT (Milwaukee, Urology): No.
Dr. R. M. WALDKIRCH (De Pere): Mr. Chairman, I would like to change my vote to "Yes."
Dr. L. C. MILLER (Green Bay): Mr. Chairman, I misunderstood the motion at first, and I would like to change my vote to "Yes."
Dr. H. M. TEMPLETON (Barron): Mr. Chairman, I would like to change my vote to "Yes."
Dr. M. V. OVERMAN (Neillsville): Mr. Chairman, I would like to change my vote to "Yes."

Secretary Crownhart: Mr. Speaker, the Secretary records the vote as forty-nine "Aye," thirty-one "Nay." Decision of the Chair sustained.

Forty-nine to thirty-one.*

Speaker Leahy: Continuing our business, the Speaker declares that the resolution submitted by Dane County Medical Society with the endorsement of the Council is properly before the House.

Under Supplementary Reports, Chapter III, Section 9 of the Bylaws reads:

> "Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the Secretary's office of the Society twenty days before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Council, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates."

Secretary Crownhart: Mr. Speaker, the Council meeting this morning adopted two reports which I was requested to transmit to you.

> In prior years this Society, acting through the House of Delegates, has both approved Blue Cross of Wisconsin and commended it for successful promotion of hospital costs protection.
>
> At the present time the State Medical Society of Wisconsin, much against its wishes and its intent, finds itself in public debate with Blue Cross, with Health Insurance Corporation, its stock-for-profit insurance company, and with its activity in promoting a county society plan competitive to Wisconsin Physicians Service but using the same trade name and symbol of "Blue Shield."
>
> It was the earnest desire and active endeavor of the State Medical Society to avoid these developments. It felt that its plan, Wisconsin Physicians Service, and Blue Cross could stand in public association without requiring either to be subject to domination or control by, or necessarily under contract with, the other.
>
> It is fruitless now to recount all the details which led to administrative parting of the ways between the State Medical Society of Wisconsin and Blue Cross. The Society had developed a new program, the Special Service contract, which required field and sales servicing of a character which Blue Cross, in the Society's judgment, was unable to supply. The Society therefore proposed its own servicing staff, with certain internal operations delegated to Blue Cross.
>
> Late in 1956, Blue Cross had initiated a demand for an increased rate of compensation from the State Medical Society which the Society felt uneconomical and unreasonable. It was the inherent right of the State Medical Society, as the owner and operator of Wisconsin Physicians Service, to deny that request which, while subsequently lowered, was never withdrawn by Blue Cross.
>
> This impasse led to ultimate administrative separation of the plans. This was a mutual responsibility and not, as some Blue Cross personnel have said, solely a responsibility of the State Medical Society of Wisconsin.
>
> It was likewise the sincere endeavor of the State Medical Society to avoid these developments. But they came about.
>
> Consistent with the Society's position that both plans could stand in public association, the House of Delegates in May, 1958, adopted a resolution seeking just that, and inviting the hospitals of Wisconsin to cooperate to that end.
>
> Within a few days, however, Blue Cross of Wisconsin, a nonprofit organization, rejected this invitation and put into operation a stock-for-profit insurance company, solely owned and controlled by it, to engage in the sale of surgical-medical policies.
>
> Apparently in fear that the Blue Cross insurance company threatened the existence of its plan, Surgical Care, (although it had assurances to the contrary from Blue Cross,) The Medical Society of Milwaukee County, by action of its board of directors, first entered into ten counties which it considered part of metropolitan Milwaukee, and then, shortly afterwards, entered into the entire state. These are regrettable circumstances. Domination and fear were judgment considerations rather than public welfare, reason, and diplomacy.

* A recount at the time of publishing these transactions reveals the actual vote to have been fifty "Aye", thirty-one "Nay."

The State Medical Society of Wisconsin—faced with the fact that Blue Cross-Surgical Care-HIC were endeavoring to switch installations of the State Medical Society to their several programs, and in the process were attacking the adequacy and stability of the plan of the State Medical Society—had no alternative but to establish its own hospital costs protection.

In doing so, it endeavored to create a "contribution" to this field, as well as a contract. It believes it has done just that. Its program is related to the costs of hospitalization in the various areas of the state and does not blend metropolitan costs with those of rural areas.

We deeply regret the circumstances forced upon us by the Blue Cross-Surgical Care-HIC alliance.

Segments of the public perhaps will now consider the State Medical Society in opposition to the principal objectives of Blue Cross, when the fact is that the State Medical Society endorses the principle of free enterprise and, in common with the American Medical Association, asserts that "The Voluntary Way is the American Way."

This position precludes the endorsement of but one approach to insuring against the costs of illness.

We are at odds with Blue Cross-Surgical Care-HIC on administrative and interplan philosophy.

We favor adequate insurance against the costs of illness, which should be their principal objective, rather than their current efforts to destroy the programs of the State Medical Society in pursuit of the same objective.

Our major concern is not size, but sufficient freedom and opportunity for the State Medical Society to continue its well-established leadership in this movement.

Despite the brazen unfairness, which should be terminated once and for all, of a county medical society joining in an effort to discredit and destroy the State Medical Society plan, and despite the most amoral of competitive approaches on the part of both Milwaukee plans in turning physician against physician, we can now report to the House of Delegates that the tide is turning.

As it must be clear to all reasonable men, the ultimate issue is one of moral courage and of responsible conduct, and with the conviction that right grows out of justice and not out of financial might, your Council stands firm in its conclusion that WISCONSIN PHYSICIANS SERVICE will continue in this state and among all plans as one conceived with the best interests of the people at heart.

We subscribe again to the statement . . .

"GIVE LIGHT AND THE PEOPLE WILL FIND THE WAY."

Doctor Strakosch (Oshkosh): Mr. Speaker, I would respectfully request the unanimous consent of the House of Delegates to introduce a resolution, a copy of which we have distributed at the beginning. If this is acceptable to the House, our Councilor then will present the resolution.

Doctor Galasinski (Milwaukee): Point of order, Mr. Speaker—may I have the privilege of the House to speak?

Speaker Leahy: Yes.

Doctor Galasinski (Milwaukee): You haven't as yet ruled on the resolution read by the Secretary. The statement just read by the Secretary, that has not been ruled on, has it?

Secretary Crownhart: Doctor Galasinski is raising the point, the statement on cost of controversy and the statement I just read require the Speaker's ruling that they are properly before the House, as I understand you, Doctor Galasinski.

Doctor Galasinski (Milwaukee): Right.

Speaker Leahy: I so rule.

Doctor Galasinski (Milwaukee): May I speak to that.

Secretary Crownhart: You want to speak to the ruling?

Doctor Galasinski (Milwaukee): Mr. Speaker, Fellow Members of the House of Delegates: This statement was read before the Council this morning by the Secretary, at which time I rose and objected to its presentation to the House of Delegates on the basis that the statement is controversial, debatable, argumentative and not entirely factual.

In May of 1957, which is the date of the inception of this particular argument, and the purpose of this particular meeting, a matter was presented to the Council as a matter primarily based on monies. At that particular time I argued that money was not the main issue, but it was a matter of philosophy and not monies. I also argued at that time that it was within the right of the Council to make such decisions and not to give full authority on this matter to its Commission on Medical Care Plans.

I wish to point out to you in this particular statement the parting of the ways between WPS and the Blue Cross may have originated before May of 1957, and that the demand allegedly for increase in rates and the controversy led to an impasse in negotiations, but this does not mean that negotiations had to be stopped. This does not mean that the impasse had to occur, for good business would mean that there could be a continuation of this relationship while negotiations proceed.

There was no reason to invoke the automatic cancellation clause. I think in my opinion this was an error. Now, you may say whom are you accusing? Let me put it this way. At that discussion there was some difference of opinion as to whether this was management or philosophy, and I was the

proponent of the theory this was a philosophical proposition, not a monetary proposition. At that particular time I also emphasized the fact that if we divorce ourselves, WPS from Blue Cross, it would mean the Society would be forced into going into a prepaid insurance program including hospitalization. This was not entirely denied. At least, I believe that the minutes will prove that no such statement was made.

Now, either then there was sincerity in breaking this relationship with Blue Cross on the basis of primary finances, or this was the beginning of a chain of events which led to what is occurring today and forcing the Society into the philosophy of hospital insurance which, incidentally, has never been decided upon as acceptable by this House of Delegates, which is supposed to be the power supreme.

The State Society states that it wanted to stand alone. I will grant you that the Blue Shield plan has grown up, and it has a right to speak like an elderly son does to his father, but that does not mean that you should not continue talking to each other, and I feel that if the two plans had kept talking to each other while being in operation, that they could have arrived at a solution which would have not brought about this present situation.

In effect, the action taken by the State Medical Society which is blaming Milwaukee now for many of the current problems was a situation created by itself. It asked for HIC. It asked for Milwaukee to extend its protection of contracts which were being lost by WPS to HIC.

I, therefore, feel that this particular recommendation or this statement read by the Secretary is not entirely factual, and I don't think it should be presented to this body as such because as I maintained in the very, very beginning, this is fraught with all kinds of matters which are not completely agreed upon by anyone, and I, therefore, feel that it is out of order to be considered by this House because it is primarily intended to blame another party for an action which it did itself.

As I said this morning, if a father gets into an argument with someone else, or let's use the simile I actually did use for the purpose of comparison. Milwaukee is the son and the State Medical Society is the father. The father goes into a fight, and he loses, so then he beats the child for having made the mistake himself, and upon that I rest.

Speaker Leahy: Doctor Galasinski might have been a little out of order. It was not debatable.

Dr. P. B. Mason (Sheboygan): Mr. Speaker, remarks have been made on this. I would like to say a few words, if I may.

Speaker Leahy: Yes, you have the floor.

Doctor Mason (Sheboygan): My name is Doctor Mason from Sheboygan.

Speaker Leahy: Doctor Mason, just before you start, I want to say that this will be the last of the discussion. You have a chance to answer.

Doctor Mason (Sheboygan): This will be very short.

Many of you may well know that I have been the conscientious objector voter to what has occurred in the separation of WPS and Blue Cross. That is, I was against not having Blue Cross as our selling and billing and enrolling agent.

This discussion in our Commission has gone on for a long period of time. It has gone on in the Council for a long period of time. Two years ago at the meeting of the House of Delegates I went to numerous Councilors including many from Milwaukee and including many of the leaders from Milwaukee and predicted what would happen and begged them to do something about it.

Now, there are a good many men on the Council who are representatives and there are many men on the Commission who are representatives, and this decision was made by the physicians. I just want to get that point across. When Doctor Galasinski speaks that they should have continued negotiations, this was tried, and when the Council referred this back to the Commission on Medical Care Plans, the Commission wrote a letter to Blue Cross agreeing to meet with the Executive Board of Blue Cross and to discuss these issues and try and join them. Blue Cross refused to meet with us. I just want to get that point across because you cannot continue negotiations unless the other side is willing to sit down and negotiate. Thank you.

Secretary Crownhart: Doctor Strakosch presented —I have forgotten whether you read it or not—he presented the substance at least of a resolution from the area which he represents. He asked for suspension of the rules to permit its formal introduction. Am I right, Doctor? That question has not been placed before the House.

Speaker Leahy: Yes.

Dr. J. G. Beck (Sturgeon Bay): I move the rules be suspended and this resolution be allowed to be presented to the House.

Doctor Willson (Milwaukee): Mr. Speaker, may I second that motion.

Doctor McCann (La Crosse): Mr. Chairman, a point of order. In the first meeting of the House, is it necessary to suspend the rules?

Secretary Crownhart: Yes.

Doctor McCann (La Crosse): I thought it was agreed that resolutions could be presented at the first meeting without prior notice.

Secretary Crownhart: May I suggest to the Speaker that it might facilitate matters if he put the question in this fashion, that unless there is objection from some delegate, he will consider the rules suspended and the resolution properly introduced.

Speaker Leahy: Is there any objection?

Secretary Crownhart: The Secretary reports no objection, and the resolution then is properly before the House.

Dr. Jerome W. Fons (Milwaukee): Mr. Speaker, you have heard the request for the introduction of the resolution. Are you going to read this, Doctor, or does everybody have a copy?

Dr. H. J. Kief (Fond du Lac): I was going to read it, Doctor Fons.

Mr. Chairman, may I have the privilege of the floor, please.

Mr. Chairman, members of the House of Delegates: This resolution is introduced by the delegates of the Sixth Councilor District, comprising Brown, Door and Kewaunee, Fond du Lac, Outagamie and Winnebago Counties.

WHEREAS the differences of opinion as to the operation and administration of Blue Shield Medical-Surgical Care programs in Wisconsin have resulted in a jurisdictional and philosophical controversy, and have created confusion in the minds of the consuming medical public, and have further created a divided medical front among certain segments of the membership of the State Medical Society of Wisconsin; and

WHEREAS all physicians agree that it is their sacred obligation to foster, preserve and protect the dignity of the fundamental private relationship that has always existed between patient and physician; and

WHEREAS the medical profession in Wisconsin has pioneered in providing a Medical-Surgical Care insurance program for the people of Wisconsin that both protects the interests of and engenders the relationships with the patient and the doctor; and

WHEREAS continued controversy can only lead to the ultimate destruction of, and the loss of confidence in such voluntary prepaid Medical-Surgical Care plans:

NOW, THEREFORE BE IT RESOLVED that this House of Delegates of the State Medical Society of Wisconsin in special session assembled conclude by orderly vote that one parent Blue Shield Medical-Surgical Care plan be maintained, fostered, and operated by the State Medical Society of Wisconsin, and

BE IT FURTHER RESOLVED that the House of Delegates representing the entire House of Medicine in the State, direct the council to appoint a new body, impartial and geographically and numerically representative, to compromise the differences, and

BE IT FURTHER RESOLVED that because of repeated failures by the lay encumbents charged with the administration of the present Blue Shield plans in Wisconsin to successfully arbitrate and solve the differences that exist, that these lay encumbents be relieved immediately of all participation in these deliberations, be relieved of administration and management of such Blue Shield Plans, and

BE IT FINALLY RESOLVED that we reaffirm the principle that any component county medical society wishing to operate its own Voluntary Blue Shield Plan under the existing statutes of the State of Wisconsin may do so with the supervision and advice of the parent State Medical Society of Wisconsin.

Dr. S. W. Hollenbeck (Milwaukee): Mr. Chairman, I will second the motion if he is putting it in that order.

Secretary Crownhart: It is before the House, Doctor Hollenbeck.

Speaker Leahy: The chair recognizes Doctor Fons.

Doctor Fons (Milwaukee): (Doctor Fons made a statement, portions of which were prepared, as follows:)

Mr. Speaker, members of the House of Delegates—

Once again we find it necessary to have a special meeting because there is division within the house of medicine in Wisconsin. During the 28 years of my practice, 25 have been spent in activity in what I call official medicine. Not always have the wheels of official medicine turned smoothly. Differences of opinion on varied issues have always existed, and will continue to do so in the future, long after you and I are gone.

Honest difference of opinion is not to be construed as rebellion, anarchy, or potential destruction of those holding an opposite view. Rather, it is healthy to have other viewpoints, and sickly to hold rigidly to one.

Just as has the scientific aspect of the practice of medicine changed with the advent of newer drugs, so too has the economic aspect changed with the advent of health insurance plans—workmen's compensation laws, maternal and infant care programs of World War II, Medicare, and the physician-sponsored prepaid program known as Blue Shield.

None will deny that all have been of some benefit and that all have some faults.

Today we are confronted with one of those faults with respect to certain administrative procedures relating to the two Blue Shield Plans operating in Wisconsin.

Wisconsin Physicians Service of the State Medical Society and Surgical Care of The Medical Society of Milwaukee County, hold opposite viewpoints anent the selling, enrolling and billing procedures to be followed—both plans, however, in common agreement as to the necessity for Blue Shield, so that the public is given the opportunity to purchase protection at a reasonable cost and with maximum benefits.

There is further agreement. Both plans—WPS, the younger of the two—Surgical Care, the older by some two years—are agreed that direction of Blue Shield Plans must be vested in the hands of physicians.

There is no disagreement here, gentlemen. The State Medical Society directs WPS.

The Medical Society of Milwaukee County owns, operates and controls Surgical Care. No one—individual or organization—has a voice in its direction.

Surgical Care has a lay advisory board of 5 outstanding civic leaders who do just that—advise—they have no voting privileges. Mr. Edmund Fitzgerald, Board Chairman of Northwestern Mutual Life Insurance Company; Mr. Irving Maier, Publisher of the Milwaukee Journal; Mr. Joseph Heil, President of the Heil Company; Mr. Richard Herzfeld, former President of the Boston Store; and Mr. LeRoy Grossman, Executive Vice-President of the Marine National Bank, comprise this lay advisory board.

They have given freely of their time, without compensation, honored by the opportunity afforded them, to serve the profession and the public.

Because of a suggestion from a member of this group of civic leaders, I have drawn up a resolution which shall be presented to you. This resolution is being heard for the first time, by all assembled here. No help was sought by me in composing it; no eyes other than mine have seen it.

It is my fervent hope and prayer, members of the House of Delegates, that you will see fit to adopt this resolution as the *only* conclusion and action, resulting from this special session, thereby avoiding further schism in the ranks of organized medicine in Wisconsin.

The bylaws state that the president shall be the real head of the profession of the state during his term of office.

As the head of a profession dedicated to providing superior medical care to the citizens of Wisconsin, I would be remiss in my duty to you who elected me to receive this high honor, if I sat here silently and failed to acquaint you with some facets of the problem confronting us today.

Many physicians throughout the entire state, have expressed their deep concern to me, relative to the state of affairs in organized medicine within Wisconsin.

I, too, am deeply concerned—concerned not only with the present issue, but also because men educated and trained to a high degree of competence, have become captives of organized medicine and prisoners of administrative personnel in the employ of SMS.

Instead of leading—we are being led.

Recommendations stated as coming from the Council, were heard by the Council, for the first time at a special meeting of the Council on September 13, two weeks ago, and accepted by the Council, as its own, within the same hour of presentation.

All had been prepared by some one in administration, without prior consultation with the Council.

Why has so much publicity come forth from SMS employees?

Why has the issue been tried in various newspapers throughout the state, as evidenced by advertisements purporting to having been the result of county medical society activity?

Is this the way you—the legislative body of the society—wish to have the State Medical Society of Wisconsin operate?

Gentlemen, I am firmly convinced that if we continue on the present course, grave legal entanglement and years of litigation will be the end result.

Do not, I beg of you, make my position untenable, lest this ribbon and medallion, worn so proudly by me, because of your faith in me, becomes like a noose about my neck, necessitating its removal as a measure of self-preservation.

For the benefit of any of you who may question—Chapter 3, Section 9, specifically states that the provision requiring unanimous consent of the House or filing of the resolution thirty days before a session does not apply to constitutional officers and so forth. Being a constitutional officer, I am in order.

WHEREAS, there is agreement within the House of Wisconsin Medicine anent the ownership, operation, and control of Blue Shield Plans, there is disagreement relative to certain administrative procedures existing in Wisconsin Physicians Service as compared to those existing in Surgical Care, and

WHEREAS, such disagreement has become so magnified and so distorted as to fact, that there is danger of an irrevocable break occurring within the House of Wisconsin Medicine,

NOW THEREFORE BE IT RESOLVED THAT—

1. This House of Delegates, meeting in special session on September 27 and 28, 1958—does hereby authorize and direct the Speaker to appoint to a special committee of the House, the following physician members of the State Medical Society of Wisconsin:

President-Elect—W. B. Hildebrand, M.D.

Vice Speaker—L. H. Lokvam, M.D.

Member of the Executive Committee of the Council—R. E. Galasinski, M.D.

AMA Delegate—L. O. Simenstad, M.D.

Secretary of Wisconsin State Board of Medical Examiners—T. W. Tormey, Jr., M.D.

W. B. Hildebrand, M.D., to serve as chairman.

2. The purpose and duty of this committee shall be two-fold—

(a) To select five non-medical, outstanding civic minded citizens of Wisconsin, from areas

other than Milwaukee County, who will agree to serve on an advisory board from Wisconsin Physicians Service—said advisory board then to meet with the lay advisory board of Surgical Care for the purpose of full discussion of the problems which prompted this special session, and the solution advised for same.

(b) To report to the 1959 annual meeting of the House of Delegates, the findings and recommendations of the joint advisory boards, following which, the House of Delegates shall take whatever action it deems appropriate, and

BE IT FURTHER RESOLVED THAT—

This House of Delegates advises and instructs its special committee, to inform the members of both advisory boards, of the desirability of conducting their discussions, after receiving all pertinent data, by themselves, and with none present save the appointed members of both boards.

That concludes the resolution. Now then, gentlemen, if sincerity is behind all the pleas for unity, then we need more than lip service, we need action, action designed to bring about that unity, not action implemented by a desire to castigate.

Gentlemen, in your deliberations remember that when the Lord measures a man He puts the tape measure around man's heart—not his head.

Thank you. (applause)

Speaker Leahy: This is properly before the House, this very fine talk of Doctor Fons. We will hear from Doctor Drew.

Doctor Drew (Milwaukee): Mr. Speaker, Members of the House of Delegates: I just wish to call the Speaker's attention to the resolution that I introduced at the opening of this meeting, and I waived the roll call vote for a period of fifteen minutes at the request of Mr. Crownhart, but I would like to have that vote taken at this time if the Chair sees fit.

Secretary Crownhart: The Secretary, Mr. Speaker, recalls the motion as one to go into the committee of the whole. That requires suspension of the rules, and a roll call. Those voting "Aye" would favor suspension of the rules and entering into the committee of the whole. Those voting "No," are against suspension of the rules and the Reference Committee would act.

Shall I proceed?

Speaker Leahy: Go ahead.

(Secretary Crownhart called the roll as follows:)

Doctor PRENTICE (Ashland): I would like to withhold my vote until I can talk to the other delegates, please.
Doctor TEMPLETON (Barron): No.
Doctor MILLER (Green Bay): No.
Doctor WALDKIRCH (De Pere): No.
Doctor OVERMAN (Neillsville): No.
Doctor INMAN (Montello): No.
Doctor DESSLOCH (Prairie du Chien): No.
Doctor STEEPER (Madison): No.
Doctor MORRISON (Mount Horeb): No.
Doctor GEARHART (Madison): No.
Doctor STOOPS (Madison): No.
Doctor HANK (Madison): No.
Doctor NORDBY (Madison): No.
Doctor GOLDEN (Madison): No.
Doctor SCHRANK (Waupun): No.
Doctor BECK (Sturgeon Bay): No.
Doctor PICARD (Superior): No.
Doctor BLOSE (Durand): No.
Doctor MOLAND (Augusta): No.
Doctor TWOHIG (Fond du Lac): No.
Doctor CAREY (Lancaster): No.
Doctor HEIN (Brodhead): No.
Doctor TAUGHER (Berlin): No.
Doctor HAMILTON (Dodgeville): No.
Doctor QUANDT (Jefferson): No.
Doctor SCHWARTZ (Kenosha): No.
Doctor SATORY (La Crosse): No.
Doctor McCANN (La Crosse): No.
Doctor CURRAN (Antigo): No.
Doctor JARVIS (Tomahawk): No.
Doctor ACHESON (Valders): No.
Doctor GREEN (Wausau): No.
Doctor BOREN (Marinette): No.
Doctor ROSS (Milwaukee): Yes.
Doctor PURTELL (Milwaukee): Yes.
Doctor CHOJNACKI (Milwaukee): Yes.
Doctor SANFELIPPO (Milwaukee): Yes.
Doctor BAKER (Milwaukee): Yes.
Doctor WILLSON (Milwaukee): Yes.
Doctor END (Wauwatosa): Yes.
Doctor HOLLENBECK (Milwaukee): Yes.
Doctor OBERBRECKLING (Milwaukee): Yes.
Doctor DREW (Milwaukee): Yes.
Doctor HOUGHTON (Milwaukee): Yes.
Doctor HILLIARD (Milwaukee): Yes.
Doctor SCHMIDT (Milwaukee): Yes.
Doctor SULLIVAN (Milwaukee): Yes.
Doctor RUCH (Milwaukee): Yes.
Doctor LEE (Milwaukee): Yes.
Doctor COLLENTINE (Milwaukee): Yes.
Doctor COLLINS (West Allis): Yes.
Doctor COFFEY (Milwaukee): Yes.
Doctor BEEBE (Sparta): No.
Doctor SANDGREN (Suring): No.
Doctor CARLSON (Appleton): No.
Doctor GUTZLER (River Falls): No.
Doctor SIMENSTAD (Osceola): No.
Doctor GEHIN (Stevens Point): No.
Doctor LEAHY (Park Falls): — (absent or not voting)
Doctor SCHULZ (Union Grove): No.
Doctor KREUL (Racine): No.
Doctor HOUSNER (Richland Center): No.
Doctor FREEMAN (Beloit): No.
Doctor DAVIS (Milton): No.
Doctor PEARSON (Baraboo): No.

Doctor JEFFRIES (Shawano): No.

Doctor MASON (Sheboygan): No.

Doctor DOCKENDORFF (Arcadia): No.

Doctor BOSTON (Hillsboro): No.

Doctor SORENSON (Elkhorn): No.

Doctor NIELSEN (West Bend): No.

Doctor BOLGER (Waukesha): No.

Doctor SCHWEI (Menasha): No.

Doctor STRAKOSCH (Oshkosh): No.

Doctor MASON (Marshfield): No.

Doctor GOLDSTEIN (Kenosha, General Practice): No.

Doctor JEFFERSON (Milwaukee, Neurology and Psychiatry): Yes.

Doctor HIGH (Milwaukee, Ophthalmology and Otolaryngology): Yes.

Doctor RITCHIE (Milwaukee, Pathology): Yes.

Doctor CLARK (Janesville, Radiology): No.

Doctor CONWAY (Milwaukee, Surgery): Yes.

Doctor SARGENT (Milwaukee, Urology): Yes.

Doctor PRENTICE (Ashland): Mr. Secretary, I now vote "No."

Secretary Crownhart: Doctor Prentice voted "No."

The Secretary records the vote as fifty-seven "No"; twenty-four "Aye."

Speaker Leahy. The motion on the committee of the whole is lost.

Doctor Strakosch (Oshkosh): Mr. Speaker, I move we adjourn.

Speaker Leahy: Is there any further business before the House?

Secretary Crownhart: The Reference Committee, I just talked to Doctor Sorenson, will convene here at two-fifteen this afternoon, an hour and a half from now in this room.

Doctor Nordby (Madison): May I have a point of order.

Mr. Speaker, I would like to inquire, due to the fact that these deliberations appear to be quite cumbersome and lengthy, if it might not be of consideration to hold a meeting tonight rather than to delay until tomorrow morning? Deliberations may not be concluded. (Applause)

I understand the Resolutions Committee will meet after lunch. Is that right? So that we continue after the Resolutions Committee comes in.

Secretary Crownhart: Mr. Speaker, there is a motion to adjourn. No time was set.

Doctor Sorenson (Elkhorn): I will second it.

Speaker Leahy: There was a motion made to adjourn. No time was set for reconvening, and there was no second to that motion to adjourn.

Doctor Kreul (Racine): I will second it.

Secretary Crownhart: I would suggest to the Speaker and to the members of the House that the individual who moved that the House adjourn, move that it adjourn until eight o'clock tonight. It cannot have the assurance necessarily that the Reference Committee necessarily will have completed its work, but at any rate, you can meet here tonight at eight o'clock.

Doctor Strakosch (Oshkosh): Mr. Speaker, I made a motion to adjourn. I amend it that we adjourn until eight-thirty o'clock.

(Cries of eight o'clock.)

Speaker Leahy: The motion was duly seconded and carried.

(The meeting recessed at twelve-fifty o'clock.)

SATURDAY AFTERNOON SESSION

September 27, 1958

The meeting of the Reference Committee convened at two twenty-five o'clock with Dr. E. D. Sorenson, Chairman of the Committee, presiding.

Chairman Sorenson: Gentlemen, this meeting will now come to order. I would like to read you as an introduction, just a few remarks I have jotted down.

I do not know what the tenor of this discussion will be this afternoon, but I do know this is a meeting of so-called, and I hope we all are, intelligent men. We all belong to an organization. That organization is composed of many units. Each unit is responsible for the parent of the organization. If anyone is unhappy with some act of the parent organization or any part of it, it is their privilege and their duty in loyalty to bring that dissatisfaction to the parent organization. If they are not satisfied with the result obtained, it is then their privilege to bring it to the House of Delegates.

This, gentlemen, is what I presume is happening today.

Now, gentlemen, in your discussions, please remember that you are doctors, educated men, intelligent, all with one objective, and that is to preserve for yourselves and your children who will follow you a free practice of medicine in the State of Wisconsin.

For men of my age and many of you, this is not too important for we shall soon be gone, but for these younger men, and I have a son of my own in the profession, I consider it of vital importance. I would hate to think of him practicing under a socialized type or system of medicine.

Gentlemen, the only way we can prevent this is by getting together and acting in unison and harmony. It has been well said that a house divided against itself cannot stand. I think that is particularly apropos at this time, and I hope that we may all come out of this and through this session with the avowed purpose of running our own house of medicine and running it in complete harmony, thinking of our own sons and daughters rather than of ourselves or of any petty quarrels that we in our own vanity or ignorance may have instituted.

Let not personal ambitions or personal animosity blind our foresight. Let us come out of this session better friends and more understanding of one another's problems. Let us thank God that we are privileged to practice our art as free men and not under the dictates of any government or any form of controlled medicine.

With that short introduction we will proceed with the business at hand.

We have three resolutions and the report of the Council to consider this afternoon. The committte has decided not to limit the time of expression. I shouldn't say that. We are going to limit the time of expression to five minutes, and at our discretion, if the particular subject is akin to the buisness at hand, we may let you talk longer. I shall expect you to conduct yourselves as gentlemen. Personalities are not to enter into this thing at all. We have a business to conduct. We are supposed to report back to the House tonight at eight-thirty, and so let us all be as brief as we can and to the point, and I shall use my prerogative as chairman of this meeting to stop any man who I think is getting out of line.

The first resolution to come before you today is the Dane County Medical Society resolution. Is there anybody here who wants to speak on this resolution?

Doctor Nordby (Madison): Mr. Chairman, I would merely like to briefly state you have all read this resolution. This was promulgated in the hopes that it would offer a solution to this problem without vindictiveness and without loss of any equity, financial loss on the part of either plan, that it would establish home rule and allowing orderly means of having a single parent organization and other plans under the parent organization while still allowing home rule in any geographical area.

It also creates the mechanism for allowing a certain area to have an exclusive franchise to represent this plan in an area where the State Medical Society would choose to refrain from entering its plan in competition with the county or area plan.

There is honest effort in this resolution to provide a mechanism by which this present controversy of the medical care plans can be orderly consummated and it is submitted in the hopes that it will do something toward that end.

Chairman Sorenson: Is there anybody else on the Dane County resolution? No one.

Doctor Sullivan (Milwaukee): Mr. Chairman, this resolution submitted by the Dane County Medical Society we appreciate is done in all sincerity, and trying to arrive at a conclusion, but I think there is one main thing that you forget. I think, Mr. Chairman, in your opening remarks you forgot one thing. You said that we are all responsible to the parent organization. I think we are getting the cart before the horse.

Let us go back to the Constitution of the State Medical Society and find out where the county medical society fits in. Article IV of the Constitution states that the state society shall consist of members who shall be the members of the component county medical societies. In other words, the base unit is the county medical society.

Article V also states the House of Delegates shall be the legislative body of the Society, and shall consist of delegates elected by the component county medical societies.

Now, the county medical society, therefore, compares to the family unit, in government setups, and is the most important part of the organization. Many of us are apt to forget these facts, particularly that an organization starts from the bottom, not from the top. The grass roots, if you will, is the all important body.

Of course, we have to have governing bodies at the state and national level, but always remember they govern only because the county society delegates authority to them to do so.

Now, what should our relationship be as a county medical society to the state medical society? The state medical society should be an organizational setup where we delegate duties to them from the county medical society for organizational purposes only. They dictate to us only because we permit it. It is the same way in any government setup. If anything questions the family, if anything questions the city, remember the family is the base unit. We delegate the powers to them. They don't tell us what to do, and, therefore, in this resolution put out by the Dane County Medical Society, they propose that the state medical society will tell each county what to do.

Well now, according to our bylaws, they can't do this unless we break the Constitution or something that we have already set up. Legally you cannot put this resolution into effect, and even if you do, we don't have to abide by it. So, gentlemen, appreciating that, the sincerity of why this was put up, I certainly recommend that it be defeated.

Doctor Collentine (Milwaukee): Mr. Chairman, George Collentine, incidentally from Wisconsin, incidentally from Milwaukee, while not completely subscribing to every self-evident truth included in the recommendations of the Council, I would like to direct attention to two with which I do agree, namely, items seven and fourteen.

Chairman Sorenson: We are not hearing that now. We are hearing the Dane County resolution.

Doctor Collentine (Milwaukee): I merely wish to point out two principles applying to the Dane County resolution with which I agree.

Chairman Sorenson: All right.

Doctor Collentine (Milwaukee): Number seven. Participation. "Participants in acceptable prepaid plans shall not be required to participate exclusively in any one such plan. This principle is applicable to any plan of community service. And this is a re-

statement of a 'safeguard' to the Standard of Acceptance approved by the House of Delegates of the American Medical Association."

Number fourteen. "The voluntary way is the American way. Free enterprise better serves in the area of sickness insurance than do programs by compulsory legislation." Parenthetically, I say by the state legislature or the federal government or the House of Delegates of the State Society. "Endorsement of free enterprise precludes endorsement of any one mechanism to the exclusion of all others. Each mechanism must be judged on its merits."

I further wish to call attention to the fact that the Dane County resolution includes no mechanism for the merging of Surgical Care and WPS, nor for their dissolution and those of us who have considered this in caucuses of our delegation are advised that the legal procedures involved would take five years.

I favor the rejection of the Dane County resolution.

Doctor Hilliard (Milwaukee): Mr. Chairman, I would like to read a statement from the Milwaukee County delegates objecting to the resolution as being improper on the following three counts.

One, the issue involves no moral or medical ethics, and is therefore not a matter of medical significance on which a state society should dictate to a county society. Medical care in one county—this is the second reason—medical care in one county and this is true in Milwaukee County, might well have problems peculiar to its location on which the state society could not be considered to be an expert nor competent. The state medical society should not dictate limiting rules. Three, again, Milwaukee County is the center of three counties which controls intimately its people and its problems, the problems of the metropolitan area. There are at least three counties involved in this area, and this resolution would be completely unfair.

Doctor Gearhart (Madison): Mr. Chairman, I have no prepared speech, but I would like to call attention to one item that was mentioned in the speech or the report from the delegate from Milwaukee.

As a small boy I grew up in a rural Iowa community. I think many of us had that privilege maybe in some place that was comparable. It is this matter of the relationship of the child and the parent. I think we have to call a spade a spade, so that I would like to refer specifically to Doctor Sullivan's remarks. I think they were excellent. I think that his points about grass roots medicine is fine. I have always held the county society is the basis of all medicine, and I think the men with whom I work will know that I feel that way in our own home town. As a small boy in Iowa, nevertheless, there were some rules regarding a parent and a son. As a small boy at one time when I ventured into territory that wasn't my own, my father came after me with a raspberry bramble and I was brought home in a hurry, and I stayed home from then on.

This morning in one of the speeches that same matter was brought up as to whether the father and the son when they get into difficulty and the father is fighting and presumably the son is involved, too, whether they keep on talking or not, and I think they should, but in the discourse this afternoon the comment was made that the county society is the basis of medicine, and that the state society is the result of the component county societies. That is true, but let's remember our grammar in that respect. We will say that the county societies, plural, tell the state society what it can do and what it will do, but the statement was made in that speech that the county society will tell the state what it can and what it can't do.

Let us remember that it is the plural, and it is the county societies in total, all of the component societies, that will tell the state what to do, not one child, not one son that they will keep talking, that they will try to keep this on a basis where it is in the relationship that it should be with the father and a son, but they will remember that the son, one son, doesn't tell the father what to do. One county society doesn't tell the state society what to do, but the county societies, plural, in their just decision can then decide and tell the state society but not one society. Thank you.

Chairman Sorenson: Anybody else?

Doctor Beck (Sturgeon Bay): Mr. Chairman, I would also like to answer Doctor Sullivan. My idea of the democratic process is that everybody expresses themselves and then that the whole organization is subservient to the opinions expressed by the organization. That means very comparable to the state government and national government. At the present time we are having trouble because the national government says the schools have to integrate. I don't believe that one county society has any more right to overrule the state society than that one state has the right to overrule the federal government.

Chairman Sorenson: Any further comment?

Dr. Paul Mason (Sheboygan): I would like to point out that probably an issue as to why we are meeting today is because Surgical Care is selling their plan with the Blue Shield symbol outside of Milwaukee County. If that hadn't come about, I doubt if we would be here at this meeting.

Now in this resolution number three, it takes into effect that the exclusive franchise to represent Blue Shield in any geographic area shall be granted at the discretion of the House of Delegates of the State Medical Society of Wisconsin.

It seems to me that Surgical Care has been in business so long, and they have done a wonderful job in Milwaukee County. They certainly would be entitled to use their Blue Shield symbol in Milwaukee County, and I would like to suggest that maybe most of our differences can be resolved in a short period of time if Surgical Care would use the Blue

Shield symbol in Milwaukee County, and then if Surgical Care still feels they must sell a medical-surgical plan in conjunction with Blue Cross throughout the rest of the state, to do so under a different name, but to my way of thinking and in my experience, and especially in my home area, it is not fair to the public to have one Blue Shield plan selling against another Blue Shield plan.

The public is confused. The public does not know what it is buying, and I could go on and document that on and on. They come into our area and say, "Just sign this little slip. You are getting more under a different Blue Shield plan." They don't really realize that they are buying Surgical Care, and they are giving up WPS.

Now we can talk all we want, and pass all the resolutions you want. It is not going to do too much good because the public is going to decide this, and I think that it is right that the public should decide it, but I think it is only fair that somewhere in a resolution of this type, that you would pass a resolution stating that the Blue Shield symbol by Surgical Care should be used only in Milwaukee County, and then if you feel you must sell outside, use a different name. I would go one step further than that. To take care of the other counties surrounding Milwaukee County, if the county medical society wishes Surgical Care to come into their area and sell and they could get over fifty-one percent, say seventy percent or seventy-five percent of the physicians of that county medical society to sign as participants, as a participating physician, in other words, sign for the full payment feature, then I think that county medical society in that area should be allowed to use the Blue Shield symbol because obviously that county society would want Surgical Care and not want WPS.

To my way of thinking that would be fair and equitable. No one wants to see any one of the "Blue" plans get into trouble. No one wants Surgical Care to go down. No one wants Blue Cross to go down. No one wants WPS to go down. We want them to succeed. Let the public decide it, but let's have fair competition and have some sort of a motion passed of what I suggested in the use of the Blue Shield symbol.

Doctor Collentine (Milwaukee): Mr. Chairman, may we ask questions of speakers like Doctor Mason who do have the information of the Commission on Medical Care Plans?

Chairman Sorenson: I don't think so at this particular hearing.

Is there anybody else to appear for or against this resolution?

Doctor Sullivan (Milwaukee): May I answer some of the remarks made on my discussion. I intended to use the plural. Maybe my grammar isn't so good as I get a little older, but Doctor Gearhart, excuse me. I intended to use the plural.

Doctor Gearhart: I accept that.

Doctor Sullivan: As far as Doctor Mason is concerned, practically everything he says I am in complete agreement with except in his first statement that we are meeting here to decide whether Surgical Care can sell outside of Milwaukee County.

Now, gentlemen, we sent you a special delegates' report telling you what we think precipitated this meeting. Surgical Care or Milwaukee County, if you will, did not want to sell outside of Milwaukee County. They still do not want to sell outside of Milwaukee County. We felt we were driven to it, and we have tried to document this to show you why we felt we had to do it. That is not the issue.

When the break was made with Blue Cross, we told you a year ago these things would happen. At the September meeting of the Council, Doctor Kilkenny presented a prophesy which has come true almost to the letter. It has happened. We think this break precipitated this whole thing. We think this was a management error, and we from our statistics, our available statistics, find that WPS has lost 74,000 participants. They were losing them to HIC. We felt we had to step into the breach, and the only way we thought we could do it was to let them sell Surgical Care out into the state to prevent the scuttling of WPS, if you will, by this management error, and it went along very well.

They have sold Surgical Care throughout the state, but this is, at least, a medically controlled plan, and, gentlemen, I assure you as soon as anything can be worked out in which WPS will be protected from a management error such as we feel it has made, they can have all the contracts back.

Doctor Schmidt (Milwaukee): Mr. Chairman, can someone tell me who owns the trademark of Blue Shield and who establishes the regulations by which the name, Blue Shield, is attached to a particular plan, Mr. Chairman?

Chairman Sorenson: Is there anybody here who can answer that question?

Doctor Dessloch: Dessloch of Crawford County, also Chairman of the Commission on Medical Care Plans. Blue Shield is a symbol of National Blue Shield. It is registered nationally and can be used by those who have a standard that is acceptable to national.

Chairman Sorenson: Gentlemen, we are getting off this resolution. Let's confine our remarks now from here in to the resolution.

Doctor Dessloch: Mr. Chairman, I would like to voice my favor of this resolution because as far as I know, all the resolutions that have been presented, none can resolve the problem as well as Dane County resolution. There are many reasons why I say so. I don't want to belabor the issue, and I don't want to take time, but if you insist, we will take the time to prove that this is probably closer to an agreement

that everybody can live up to than anything that has come before this Special Session of the House of Delegates.

I certainly urge the Reference Committee to look with favor on this Dane County resolution. It can be improved in part, but in essence, it is the finest of the resolutions presented.

Doctor Morton (Milwaukee): Doctor Morton, president of The Medical Society of Milwaukee County. There has been a good deal said here about the requirements of the use of the symbol Blue Shield, and also it has been intimated on several occasions The Medical Society of Milwaukee County was operating illegally.

I think it would be of benefit to all to read into the record the legislation and the regulations by which we operate, and I think it is very pertinent to the subject, sir, and I will read the Wisconsin Statutes, Chapter 148, Section 3-A. The state society or county society in a matter approved by the state society shall have the power to establish in the state or county or counties therein a nonprofit plan or plans of sickness care, of indigence and low income groups and others through their contracts with public officials, with physicians and others, and by the use of contributions, cooperative funds and other means provided only that the free choice of physicians within such contracts shall be retained and the responsibility of the physician to the patient, and all other contract and tort relationships with the patient shall remain as though the dealings were direct between the patient and the physician.

Thus, gentlemen, by the enabling act, The Medical Society of Milwaukee County is permitted to sell through the entire state, and it did sell through the entire state from 1943 to 1946, and once the State Medical Society has approved the manner of establishment, which they did, they no longer have any supervision over the operation of Surgical Care.

It is exactly similar to the Banking Commission approving the manner of establishment of a bank, just to make sure it is adequately and satisfactorily established.

Now regarding the Blue Shield symbol. The membership standards of the Blue Shield Medical Care Plans state in Section 4, participating physician agreements: If a plan utilizes participating physician agreements, which in any way affect the services and/or benefits provided in the subscriber certificates, such plans shall secure and maintain the participation of not less than fifty-one percent of the eligible doctors of medicine practicing in the area served by the plan.

Now, the area for which we are licensed is the State of Wisconsin, and we have over fifty percent of the doctors in that area, and are thus permitted to use the Blue Shield insignia. Thank you.

Chairman Sorenson: Anybody else, gentlemen, on the Dane County resolution?

Doctor Bernhart (Milwaukee): Mr. Chairman, the Dane County resolution does not refer to the thing which caused our present controversy, the Blue Cross situation. It doesn't mention a word about our selling agent or the administration agent, and I feel for that particular reason we should reject that particular resolution because we are not getting down to the nubbin of our controversy.

I would like to further state that in my opinion as long as our philosophies and ideologies with Blue Cross are so different, why doesn't the medical profession in the state sell an entire medical plan and let Blue Cross sell the hospital plan, and I think then with a liaison committee on general principles, we could get along and all be friends. I think we all agree that we need the hospitals, and we all know that we need a united front in the house of medicine. I think I have been on the road talking companion plans for a long time, but in the last few weeks I have felt that the philosophy and our ideology differs so much with the Blue Cross philosophy that I think if we doctors would sell a medical-surgical plan, let the hospitals sell the hospital plan only, I think then we can resolve our situation, and we could all be friends and smile together again. Thank you.

Doctor Waldkirch: Mr. Chairman, I have no prepared speech of any kind. I am here today only to try to unite the house of medicine. I sit back, and while I am no mental genius, I can see that we could be here for three or four days and argue about details and never get anywhere.

I am sure that the boys in Milwaukee County, and you know that they seem to be on one side of this controversy and the rest of the state seems pretty clearly to be on the other side. I have many friends in Milwaukee County, and I know they are just as good doctors and just as sincere, and they are just as worthy of our love as we are of theirs.

I am interested today in getting this job done, and I want to be sure that this job is done in time so I can get back to the Bear game in Green Bay tomorrow, and pursuant to the overwhelming job that I have to do to get back to that Bear game, I would like to see whether a few remarks of mine wouldn't help to get this show on the road.

I have three or four things written down here that I think we will have to agree on if we are going to get anywhere. The first one is that we must have one plan throughout the state. The speaker just before me, or a few speakers back, said that we could start a new plan, sell in Milwaukee County under Blue Shield and sell in other counties without the Blue Shield. That will simply add another number to all the other plans that are coming up.

Chairman Sorenson: Doctor, let's confine our remarks to the resolution, please.

Doctor Waldkirch: I believe that it has to do with it. I am in favor of rejecting the Madison resolution

and taking the best of all the plans and uniting them into something that I think we can all agree on. I think the thing that we also must agree on, number one, is to have one plan throughout the state, and so that the public knows that this is the doctors' plan for the whole state. There can't be any division, but there can be a Milwaukee County plan as a subdivision of the state plan.

Number two, the doctors like Doctor Bernhart said, must run their own plan. We cannot depend on Blue Cross to sell our plan for us because their heart and soul is not in our problem. Their heart and soul is to sell hospital insurance, but not to sell the doctors' plan. If you boys in Milwaukee have not had to do with the A and B plan, we in the state have had to struggle with the A and B plan, and we always come out behind. We always come out second best.

If you were a salesman, and you were selling some group both the hospital and the doctors' insurance, whose would you favor? It would be just natural for you to favor the better hospital plan and leave the doctors' plan as the second best.

They are in competition with all the other insurance companies, with Metropolitan and with all the others. They have to give these groups that they are talking with. They have to talk price with those groups so they can talk price with them, but at the expense of the doctor.

The Governor of Wisconsin has the B plan. He has hospital and surgical insurance, but he carries Blue Cross and he carries the B plan on Blue Shield. He is a millionaire, isn't he? (Laughter) Or pretty close to it. (Laughter)

At least, he is certainly above the income group that was intended for the B plan. So that I am heartily in favor of divorcing Blue Shield from Blue Cross. We can work together, but still we can sell them separately.

Number three, I believe that the Milwaukee group will have to recognize the primacy of the state medical society. I believe that that is self-evident. I cannot see how it can be otherwise.

A father, if we want to use that same illustration, cannot abdicate his place as the father in the family to his oldest son. It just doesn't work that way.

And finally, I think we should take the best features of all of these plans and combine them into something workable, but it is going to be impossible for us as a large body here to accomplish that. So we must delegate this thing to a group of men that we all have confidence in, and the Milwaukee group certainly will have some voice in picking the members of the group that will work out all these difficulties, and the rest of the state should have a voice in picking the men for a committee who will work this out.

I think if we keep all these rules in mind, reject the Madison resolution, but pick out of it what is good for an entirely new resolution, something along the line of the general principles that are outlined in the resolution proposed by the valley group.

Chairman Sorenson: Gentlemen, just a minute, please.

Doctor Willson has a couple of questions he is going to ask. They are not for discussion at the present time.

Doctor Willson: Thank you. This is not a speech. It is a question. The question of the legality of the Dane County resolution has been raised. I would like to ask the Dane County proponents as to whether they have had legal opinion regarding this for the benefit of the Resolutions Committee, and, second, I would like to ask the Dane County proponents as to whether or not they have looked into the possibility as to whether or not the separation of geographical areas of operation throughout the state might not be considered by the Attorney General to constitute collusion and restrain of trade to the public's detriment and contrary to the principles of the Sherman Anti-Trust Act.

Chairman Sorenson: Is there any more?

Dr. W. J. Houghton (Milwaukee): I oppose the resolution. This is the explanation. I would like to say this. It looks to me that the only purpose—and I think we should look at it this way—of the Dane County resolution is to either force Surgical Care back into the Milwaukee County, or to give the State Medical Society a tool with which to revoke Milwaukee County's charter. I am opposed to it.

Doctor Nordby: Did you want an answer to these questions?

Doctor Willson: Yes sir, I would like an answer.

Chairman Sorenson: Have you an answer you can give?

Doctor Nordby: As to our obtaining legal opinion, we have neither the talents available to us nor the money in our treasury to obtain a legal opinion on this, and this is purely an amateur resolution drawn up by three of our delegates and submitted to the entire delegation with no advice from any attorneys or anyone with any knowledge at all of constitutional law.

As to the geographical areas, being in restraint of trade, I would presume that would depend on how this was accomplished. Again, we have no legal opinion. I am certain that the committee can be advised by those of counsel to the State Medical Society as to any legal implications of these.

This term, geographic limits, was made so that we did not necessarily limit it to counties, but if there were geographical limits which naturally fell in an area of service in other respects and was invited by the county societies to cooperate, as Doctor Mason pointed out, this would be perfectly

possible under this type of agreement, and I doubt that it would be any more exclusive than had been the so-called gentlemen's agreement in the past.

If implications are read into this resolution which Milwaukee delegation feels are aimed at revoking their charter, it was not our intent that this be done, and I would apologize as one of the authors of this for any such intent being present in it. It is, as I stated initially, purely our idea of a mechanism. It isn't the end result. I am sure, as you are, the Resolutions Committee might embellish it or change it in any way it saw fit to accomplish this end if it doesn't do it, but we submit it in good faith with this aim in mind.

Doctor Prentice: Mr. Chairman, the first sentence in the resolution as brought forth by Dane County states this House of Delegates at this meeting establish by vote one Blue Shield plan to serve the State of Wisconsin under the direction of the House of Delegates of the State Medical Society of Wisconsin.

If I interpret Doctor Sullivan's remarks correctly, and if he is representative in what he says as the feeling of the Milwaukee County men, if I understand him correctly to say Milwaukee County was ready to cooperate in one plan in which we can all agree, it seems to me we have accomplished what we are here for. This Dane County resolution represents one thing, one side, what Doctor Sullivan says represents what Milwaukee County is seeking. It seems we are both seeking the same thing. It seems to me that settles the whole situation.

Chairman Sorenson: Anybody else?

Dr. S. L. Chojnacki (Milwaukee): I would like to know whether or not it has been definitely established that WPS has fifty-one percent of the doctors throughout the state who have signed to participate in their plan number one, and, secondly, whether WPS has by any law, the power to sell hospital insurance throughout the state?

Doctor Dessloch: Mr. Chairman, do you want the question answered? The answer is yes on both counts. If you want the names of participants, they are available. If you want the authority for our hospital rider, it is available, so there you are.

Doctor Kreul: Point of question is all I want to ask, and that is along the same line. Does Milwaukee Surgical Care have fifty-one percent participating physicians in the State of Wisconsin?

Doctor Morton (Milwaukee): Mr. Chairman, I just made that statement. We do have, yes.

Doctor Overman: I would like to have Milwaukee explain how or when they got the fifty-one percent from the state at large.

Doctor Morton: I think that is just a little beside the point. Actually, we definitely have over fifty-one percent.

Doctor Overman: How would you get it?

Doctor Morton: The doctors signed the agreements themselves.

Chairman Sorenson: Gentlemen, let's stay with the Dane County resolution. Let's not get off on tangents. Let's get through with this thing.

Is there anybody who wants to talk on the Dane County resolution for or against? It is cut off.

The next matter to come before you, gentlemen, is the Special Report No. 14, the recommendations of the Council. You all have them, I expect. Do you want me to read the recommendations of the Council? They are quite lengthy. It is going to take a little time.

There were five recommendations. Number one.

"In a special report to the House of Delegates in 1938 of the Special Committee to Study Hospital Insurance, upon which there were physicians, hospital administrators, and others, the House received and approved a statement that '*a hospital insurance plan is and properly should be subject to the regulation of the insurance department of the state. The thousands of people who will pay into a group hospital fund, in expectation of receiving hospital care if sick, are as much entitled to protection by the state as are persons who pay premiums to an insurance company in the expectation of receiving any other indemnity in case of loss, depending upon the type of insurance. The welfare of a great mass of people is no different in either case.*'

"In the initiation of hospital service plans and of medical service plans the plea was made that they be exempt from virtually all insurance department supervision. Such was not the position of the State Medical Society of Wisconsin. Such plea, however, was accepted by the Wisconsin Legislature.

"The development and acceptance of voluntary health plans in Wisconsin during the past decade has been little short of phenomenal. The purchase of this type of protection has become accepted as one of the practical necessities of regular budgeting by a substantial majority of the households of the country.

"If the privileged status of exemption from all but a very few provisions of the insurance code was warranted at the time of planning and development of these programs, it was because they were venturing in a relatively uncharted area.

"The Council will conduct a special study of this subject to the end that minimal legislation be supported in the 1959 session of the Legislature which will assure sufficient supervision of these plans that their impact on the economic aspects of health care may be carefully guarded."

That is number one. Is there any discussion?

If there is no discussion, we will go on to number two.

"The Council recommends that . . .

"Since officials of Associated Hospital Service (Blue Cross) have stated their disinterest in sparsely settled areas of the state . . .

"Since the current policy of Blue Cross provides varying benefit payments to hospitals in various areas of the state, although the rates charged subscribers are essentially the same . . .

"Since it appears that the operations of Blue Cross are not only chiefly metropolitan in character, but, consequently, directed and influenced by metropolitan hospitals . . .

"Since the record of Blue Cross has been one of consistent rate increases which, while doubtless justified, may be caused more by metropolitan areas than the less densely settled areas of the state . . .

"Since published reports of Blue Cross for 1958 show consistent monthly losses, with the inevitable consequence that further rate increases are indicated in the near future . . .

"Since the State Medical Society of Wisconsin and the two hospital associations in Wisconsin stood sponsors of the law under which Blue Cross exists in this state . . .

"Since this program grew out of a special study by the State Medical Society in 1937–38 . . .

"A special committee to study hospital insurance be created in the image of the 1937–38 committee, which represented the various hospital interests in this state as well as the State Medical Society; that such committee be appropriately financed and instructed to engage in a special study considering such ways and means as may exist to solve some of the hospital economic problems confronting the people in the more sparsely settled areas of the state; to examine current policies with a view to determining ways and means of controlling misuse to the detriment of all concerned; to examine into the bargaining mechanisms between hospitals and Blue Cross, and to offer its recommendations to an ensuing session of this House of Delegates upon these and such other points as may be deemed valid to its study, including the question of whether the public convenience, need, and economy would be served by the organization of a second Blue Cross program which, while operating of necessity throughout the state, would concentrate its efforts principally outside of Milwaukee County.

"If this recommendation is approved by the House of Delegates, the Council will proceed forthwith to the development of such a study and will seek the cooperation of its Charitable, Educational, and Scientific Foundation which has already accumulated over $10,000 for the purpose of studying the costs and the possible control of costs of hospitalization. The Council will direct a further appropriation to that Foundation and will ask that the Foundation seek contributions from other interested parties to the end that the study will be detailed and implemented with the skillful assistance of actuaries, accountants, and attorneys especially interested in this area."

That is number two. Is there any comment?

Doctor Collentine: Mr. Chairman, I would like to make one single comment. Would it not be appropriate to include in the last sentence of this reasonable recommendation that the study be detailed and implemented with the skillful assistance of actuaries, accountants, and attorneys and lay advisors representing the possible subscribing public.

Chairman Sorenson: Thank you. Is there any further comment?

Number three.

"Every county medical society is directed to amend its bylaws to the end that it will conduct no functioning operation within the territorial jurisdiction of another county medical society unless with the formal consent of that society and with the approval of the State Medical Society.

"If this is not voluntarily accomplished and made effective by the end of 1958, and retroactive as to any existing program in violation of territorial jurisdiction, the Council will, under the provisions of Chapter VI, Section 4, recommend to the 1959 session of the House of Delegates that the charter of such county medical society be forthwith revoked and immediate efforts made to reorganize such county society so that it conforms to Chapter 148 of the Wisconsin Statutes.

"The Council will, prior to making any such recommendation to the House of Delegates, conduct conferences or call special meetings with members of such county medical societies to the end that democratic membership activity may supplant autocratic officialdom, if such appears necessary."

No comment? We will take number four.

"The Council determines that the use by The Medical Society of Milwaukee County and by Associated Hospital Service (Blue Cross) of the symbol and term "Blue Shield" in all counties of the state where it has been used to identify Wisconsin Physicians Service for more than ten years is producing both professional and public confusion, appears to be misleading to the purchaser, and is destructive of the very objective of promoting the symbol and name as indicative of doctors' plans working in harmonious effort.

"The Council asks that the House of Delegates approve its contemplated action of presenting such usage to public officials in Wisconsin to determine whether the same is not in violation of fair and ethical advertising standards self-imposed upon the insurance industry."

Any comment?

Doctor Sullivan: Mr. Chairman, I apologize for being on my feet so much. I would like to comment

if you will permit me to go back. You didn't give me enough chance to get on my feet about this recommendation that every county medical society is directed to amend its bylaws to the end that it will conduct no functioning operation within the territorial jurisdiction of another county medical society unless with the formal consent of that society and with the approval of the State Medical Society.

Gentlemen, this morning we read a communication from the Council in which we were labeled arrogant. There were some other epithets, too. I forget Probably they are true.

We are now told that we will amend our bylaws, or if we don't the County Medical Society of Milwaukee will exist no more, and they will produce a new medical society in the environs of Milwaukee.

Now maybe this is necessary, and I am sure that the Council deliberated on this and thought this was a good idea, but I would suggest, gentlemen, that this type of thing be sent back to the county medical societies for their discussion. I would also suggest that the language be just a little more courteous. I think we can get together on many of these things, but when inflammatory remarks come out of the Council such as this, it is a little hard for me to hold my temper.

Chairman Sorenson: Gentlemen, any comment on number four? Is that on three or four?

Doctor Morton (Milwaukee): On four. Gentlemen, this business about the Blue Shield symbol, I thought I made it very clear when I spoke before that this matter of the use of the Blue Shield symbol is not something that is in our control. The use of the Blue Shield symbol is the function of the Blue Shield Commission. I read you that. As long as we have the participating physicians' agreements of fifty-one percent in the area that we serve, by the authority of the Blue Shield Commission we are permitted to use that symbol. It is not a decision for the state. It is not a decision for the local people. It is a decision of the Blue Shield Commission, and we have maintained and we have met the necessary requirements of the Blue Shield Commission to use that symbol.

Chairman Sorenson: Doctor, may I ask you one question right now? Do you have fifty-one percent of the ten counties just adjoining Milwaukee County? Have you a tabulation of that?

Doctor Morton: I cannot answer that question, sir. I can get the answer for you.

Chairman Sorenson: You can? I should like to have it for the Reference Committee.

Doctor Morton: We have it for the whole state.

Doctor Gearhart: Mr. Chairman, in reference to this matter of fifty-one percent participating physicians, I would like to ask for a count of the entire state for this reason, a very specific reason. At one time my name was on that list, and the statement was made by Doctor Morton that over the years these names had been accumulated. My name is now off that list. I have a letter to prove that. I want to know that my name isn't counted as one of those fifty-one percent. May we have a count for the whole state?

Chairman Sorenson: Doctor Morton stated he would get it for the whole state. Didn't you?

Doctor Morton: I said I would get it for the ten counties. We have something in the order of seventy or seventy-five percent for the counties adjoining Milwaukee.

Chairman Sorenson: Can we get it for the whole state?

Doctor Morton: I said we had over fifty-one percent.

Chairman Sorenson: We would like to see a definite count of that if you have it. You don't?

Doctor Morton: We don't have the agreements with us.

Chairman Sorenson: Any more comment on number four?

Doctor Waldkirch: Mr. Chairman, I would like to suggest that maybe they have in many counties more than fifty-one percent up until this date, but whether that will hold true from this day on is another question. (Laughter)

Chairman Sorenson: That may be the truth. I don't know. Is there any further comment? If not, we will go to number five.

"The Council reports to this special session of the House of Delegates that the operational impact of both county and state societies in various fields of prepaid insurance, public welfare, contracts with government agencies and numerous other activities, must be recognized as substantial, of great importance, and demanding of the maximum deliberation and consideration by the House.

"It has been traditional that the House of Delegates meet during the course of the Annual Meeting of the State Medical Society. That tradition once implemented the scientific meeting, but now carried out to the proper extent defeats its own purpose.

"The Council therefore recommends to this special session of the House of Delegates that because of the necessary information to be supplied it and the opportunity for it to constantly study the philosophy and policies of these important activities in Wisconsin, its business meetings henceforth be scheduled at a time and place other than during the course of the Annual Meeting; but that during the Annual Meeting there be set aside a sufficient period of time for the House of Delegates to be assembled for the purpose of receiving information only, unless the Council recommends matters of such urgency as requiring special action."

Any comment? Doctor Willson has asked me to read this.

Doctor Prentice: May I go back to the resolution previous to the last one relative to the number of participants that the Milwaukee County has?

Chairman Sorenson: Yes.

Doctor Prentice: I think you can all remember that within a short time, I think possibly within the last two or three weeks, most of us throughout the state have received a form from Surgical Care asking us to sign up, to take part in the care of patients who carry Surgical Care coverage.

Now, I am not sure, in fact, if I hadn't had a little leisure time at the moment it came across my desk, I would have signed it and sent it back. After thinking about it for a short time, I thought, well, this probably is going to bring about some misunderstandings, and I believe that there probably are a number of men throughout the state who received that form to sign, and signed it and sent it back without realizing or intending they were going to sign up for Surgical Care to the extent that they would give Surgical Care the majority of the physician participants, the majority of the physicians in this state, joining in the plan. I think there are a lot of men in the room who got them, signed them, and sent them back, and didn't realize what they were doing.

Chairman Sorenson: Doctor Willson asked me to read this. It was relative to the last recommendation of the Council. Chapter 3 of the Constitution and Bylaws entitled the House of Delegates, Section 1. The House of Delegates shall meet annually at the time and place of the annual session.

In order to change that, we go to Chapter 14. These bylaws may be amended at any annual session by a majority vote of the delegates present at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid over for one day.

That practically eliminates that from our discussion at the present time. Is there any further comment on number five?

The next matter to come before us is the resolution introduced by the Sixth Councilor District, comprising Brown, Door and Kewaunee, Fond du Lac, Outagamie and Winnebago Counties.

Doctor Strakosch: I think, about this issue, it has been said that it has more to do with the philosophy and disagreement of philosophy rather than with monetary facts. Therefore, let me say that some of my remarks will be in a philosophical vein. I think one can say about this issue what is being said about our foreign policy, to be utterly confused means to be well informed.

Parts of this issue have long left the realm of reason and have mitigated into the realm of sheer insanity. If it is the obligation of the prosecuting attorney, as it usually is, to confuse the jury by confusing statements, they ought to be congratulated on both sides.

I am one of the co-drafters, spelled with "d" and not with "g", of a resolution presented by the Sixth District Council. This resolution is intended to be a blueprint only. It is a starting point and is only intended to be a blueprint. It is intended as a starting point for the conservatives on both sides to rally around and come to an agreement.

It was felt, or it is hoped, that this resolution may offer a base on which all of us can come together and compromise our differences.

As I gather from the various statements, the main objection on the part of the Milwaukee delegation is a distrust of the State Medical Society and is a distrust of the Council and is a distrust of the officers.

The accusation has been made, or insinuated, that we are not running a democratic society, that we are being run by one individual. In the same breath, the Milwaukee County Society tries to make us believe that a board of five over whom the rest of the state has no veto power—we cannot chastise them, we cannot elect or throw them out—in the same breath they believe that five is more democratic than twenty-five. And at the same time I would like to state that their own county medical society did not have their stand until just last Friday.

Since this is a nonprofit plan, the question is what is this all about. Is it power? The Milwaukee Medical Society states that they have to protect themselves, protect themselves from whom? In the deliberations I have not heard one statement as to how medicine in the State of Wisconsin is going to be protected, or how the patient is going to be protected. Doesn't he enter into it?

If the allegation should be correct, if we assume it is correct that all the power has migrated to the hand of one, then the fault is surely not with the one who has the power, but those of us who have by default let it go to him. The fault lies not with him, but all of us. We have been negligent. We have elected delegates who were not delegates, and the delegates have elected councilors, and so on. So the fault goes right back to us.

You know, duck season is on right now, and it is usually a mistake to shoot at the duck. A lot of people are turning their guns at the ducks, some thinking it is Charlie Crownhart, another one, Dr. Don Willson. Both are missing the duck.

Now if they would lead and hit the fancy bird and the feathers would fly off, they would find that the skin of the bird is blue and has a cross on its side. (Applause)

Now HIC—or excuse me, Health Insurance Corporation, has been incorporated by Blue Cross. As far as I can see for no other purposes than to whip or to be a club for Surgical Care to go along.

Since Surgical Care is operating HIC has gotten the hiccups and has stopped.

I would hate to see us, I would hate to see Wisconsin medicine, and I would hate to see Charlie Crownhart or any of us to be crucified on the cross, the color of which happens to be blue. (Applause)

Chairman Sorenson: Is there any further comment on this resolution? To or for, for or against?

Doctor Beck: I am from a part of the Sixth Councilor District. Our delegation didn't come here to fight Milwaukee County. Our delegation didn't come here to appease Milwaukee County. Our delegation came here to try to get together with Milwaukee County.

We felt, I might say we decided what we wanted to do about seven o'clock, and about twelve-thirty we got through drawing up the wording we presented. We feel that this litigation has gone on to such an extent, that personalities have entered into it to such an extent, that at the present time people cannot, some individuals cannot, enter into a definite, cooperative meeting of the minds, and, therefore, our suggestion that an attempt at reconciliation be made without either incumbent lay adviser being present.

Doctor Carlson: I had no finger in the writing of this resolution by our district. It is my own fault. I am entirely in agreement with this resolution with the exception of the words: be it further resolved that because of repeated failures by lay incumbents charged with the administration of the present Blue Shield plans in Wisconsin to successfully arbitrate and solve the differences that exist, that these lay incumbents be relieved immediately of all participation in these deliberations, be relieved of administration and management of such Blue Shield plans.

Again you are dealing with personalities. I feel that the Board of Directors of Surgical Care who are doctors and that the twenty-eight or twenty-six doctors who rule and control WPS are doctors and are able to handle the situation, and I oppose this part of this resolution criticizing the lay members of our groups.

I think they are very capable, and I think that they have done a remarkable job, but they have done it under the control of the doctors, and they have helped the doctors, and I am against that part of this resolution.

Chairman Sorenson: Further comment?

Doctor Collentine (Milwaukee): Mr. Chairman, the delegation from Milwaukee County agrees that its lay incumbents should not be charged with failure to reach agreement. At a meeting of The Medical Society of Milwaukee County, a special meeting held last Monday night, attended by a far above average percent of the members of The Medical Society of Milwaukee County, the action of the Board of Directors was reviewed in great detail and practically unanimously approved. This should refute any idea that autocratic officialdom is dictating policy in Milwaukee County.

We stand behind what they have done, and we are philosophically opposed to the idea that one Blue Shield plan has to be forced down the throats of every doctor. Participation in the Blue Shield plans is voluntary. If the doctors here and the doctors not here do not like the way Surgical Care is operating, it is possible for them not to sign participating agreements, and if they have signed participating agreements, it is possible for them to be revoked.

Our lay incumbents tell us that eight hundred doctors outside of Milwaukee County are participants in Surgical Care, voluntary participants, and that since Surgical Care went statewide, two requests have been received that their participating agreements be voided. One of those was from a man for whom no agreement to participate could be found.

Now let's leave it to free enterprise. Let those who wish to participate, participate, and if less than the required number wish to continue to participate, then the House of Delegates or the National Blue Shield Commission has the right to tell Surgical Care that it cannot operate in the area in which it is now authorized.

Chairman Sorenson: Anybody else?

Doctor Hollenbeck (Milwaukee): I would think it would be interesting and pertinent to this type of resolution if the group here were apprised of a decision that came out from the American Medical Association in 1946 when this battle first started and went through both legal courts and to the higher jurisdiction of the American Medical Association.

I have been interested in this subject and have perused pages and pages of material. It wasn't until about two weeks ago I found out, and I don't think many of you men know either unless you have been very intimately associated with this, that a problem very similar to what we are going through today went to the American Medical Association, to one of their big commissions for a ruling, and that ruling did come out, and I wish somebody here today who knew more about it than I do, because I was a rookie at that time, would just enlighten this august body to see what the decision was.

I can remember that something like this came out: that there should be a committee set up that would not be headquartered in Milwaukee or a new system, it seems to me, or new commission should be set up, state representative men, both Milwaukee and through the state, and when they would run these plans, when they were amalgamated, the headquarters would not be in either Milwaukee or Madison.

I don't know whether that is right or not, but I would like to have someone give it to this group.

Chairman Sorenson: We had a breakfast meeting this morning. We had a letter signed by Doctor

Dawson and Doctor Schluetter of Milwaukee County, and in that letter it detailed the results of that American Medical Association meeting.

We didn't have the verbatim report, but we had the quotes that were essential to this particular situation, I think. And if the men would like to hear those quotes, we can read them right now.

(Cries of "Yes.")

Doctor Willson, you have them. Will you read them?

Doctor Willson (Milwaukee): This is a very difficult task because the pages here are only some of the material and perforce I must abstract it.

I first raised this question in Milwaukee two or three weeks ago and asked our administrative staff what happened in 1946 and 1947, how did this occur. They said they would get photostats for me of some of the pertinent literature. I may not have all. I know I haven't them, not all of the material, but I will try to read from some.

This will take about ten minutes; if anyone objects to that I will stop, but I am going to time it for about that much time.

September 22, 1943, the Medical Extension Committee of the County Medical Society was held for the express purpose of starting Surgical Care on the Pressed Steel Tank Company and I think no more need be said than the fact that it did this on approval of the Council of the State Medical Society.

The next I have is an agency agreement, the first one on the 29th day of November of 1945, between Surgical Care and Associated Hospital Service setting up the details of these sales and that is not particularly important.

Now we come into the meat of this. There was a special meeting of the House of Delegates in June of 1946. In those years our meetings annually were in the fall, and this resolution was adopted by this House of Delegates. This, I think, should be read in its entirety.

In view of the belief of the Milwaukee Society that Surgical Care should be expanded outside of Milwaukee County, we favor action by this House of Delegates to establish on a state-wide basis and through our state society a plan of prepaid medical care of the character of Surgical Care of Milwaukee County. We also favor this House going on record in appreciation of the devoted and arduous labors of the medical society in Milwaukee County in the field of experimental prepaid medical insurance.

In view of this experience we seek its cooperation in developing this state-wide program which would as soon as is possible absorb Surgical Care in Milwaukee County.

We, therefore, offer the following resolution:

> One, resolved that the House of Delegates create a committee to arrange the establishment of a state-wide prepaid medical care organization of the character of Surgical Care, this committee to arrange for the absorption of Surgical Care in Milwaukee County at the earliest feasible time and the proposed plan to be mailed to the delegates and alternate delegates not less than ten days prior to the next annual session of the House.
>
> Number two, resolved that this committee shall be composed of nine members to be appointed by the Speaker of the House, three members from recommendations from the delegation of Milwaukee County, one from Racine and Kenosha counties, and five from the state at large outside of Milwaukee and Racine and Kenosha counties, all appointments to be ratified by the House of Delegates.
>
> Three, the plan be so devised as to permit it to be sold in conjunction with the Blue Cross plan of hospitalization, that the divorcement action of the House of Delegates in 1940 with respect to the separation of the State Medical Society and Associated Hospital Services, Inc. be rescinded.
>
> Four, this House of Delegates approve the manner of establishment of the Surgical Care Plan of Milwaukee County.
>
> Five, this House of Delegates urge the wholehearted cooperation and support of all physicians with the plan authorized under this resolution as well as their continued cooperation with the Wisconsin plan.

That is the resolution that was accepted and passed.

Now here I must abstract. At the annual meeting of the House, three months later, this communication is dated September 25, 1946. There is a minority report of this committee of nine members. I do not have the majority report. I do not know any of the details of it. I will stand corrected and I may be giving you biased information, but this is what I have been given. Let me give you the accompanying letter.

> Dear Doctor:
>
> In order that the coming meeting of the House of Delegates can be conducted without undue misunderstanding, we call your attention to the fact that there will be two reports from the Special Committee on Prepaid Medical Care. We urge that you read this report carefully and thoroughly in order that you will understand it when it is presented before the House of Delegates, and this is signed sincerely, Dexter H. Witte, Chairman, John W. Truitt, Jerome W. Fons. They were the three Milwaukee members.

Now in this minority report, I am not imposing any biased opinion. I am trying to be objective. If

anybody is anxious about it, sir, do you wish that I continue? I will try to be unbiased.

Chairman Sorenson: Does anybody object?

Doctor Hamilton: I would object to the minority without the majority report also being given.

Doctor Willson: I think that is a valid objection myself.

Chairman Sorenson: We don't have the majority report.

Doctor Dessloch: I have it. I have the majority report.

Chairman Sorenson: Do you fellows want to continue this thing?

Doctor Willson: I think that rather than hashing over the majority and the minority report, if you will permit me—

Chairman Sorenson: Why don't you go on to the recommendations of the American Medical Association?

Doctor Willson: May I read this one paragraph?

Chairman Sorenson: Yes.

Doctor Willson: There was a question of why the two groups couldn't get together. This single paragraph is quoted verbatim.

> "Is it unreasonable then for the Milwaukee Society to ask that if and when this plan is turned over to the state operation, it be given assurance that the plan will not be so modified that it will fail? The Milwaukee Society has very definite moral obligations to the subscriber, to the public, to industrial laborers and so forth, that the plan will continue to operate in sound successful operation."

The minority report had five recommendations. I will not read them because they were not covered.

At that time there was a suit. I am not going to read that either.

Chairman Sorenson: Go right to the American Medical Association report.

Doctor Willson: We waited for the American Medical Association report.

Here it is. The report to the membership of the State Medical Society of Wisconsin. This is signed by Dr. C. A. Dawson, President of the State Medical Society, and by Dr. U. A. Schlueter, President of the Milwaukee County Medical Society. Letter sent to the membership, and it gives the results of that meeting.

Dear Doctor:

The purpose of this letter is to inform the doctors of Wisconsin of the action taken by the Council on Medical Service at the American Medical Association's convention in Atlantic City on June 8, 1947, with regard to the service plans for prepaid medical care in the state. The Council's decisions here were set forth in their entirety.

There are at the present time in the State of Wisconsin two prepayment medical care plans, one known as Surgical Care of Milwaukee County, and the other known as the Wisconsin Physicians Service. Many difficulties have arisen in the development and conduct of these plans. The problems seemed of such magnitude, and so difficult of solution, that the Council on Medical Service of the American Medical Association was asked by the parties concerned to arbitrate and make final settlement. Every member of the Council has studied carefully the briefs presented by The Medical Society of Milwaukee County and the State Medical Society of Wisconsin.

The Council has also heard oral presentations by representatives of both societies citing the viewpoints of each. The Council has given earnest, serious consideration to the briefs and oral presentations and decides as follows:

One, that a new plan be formed comprising both the Wisconsin Physicians Service and the Surgical Care of Milwaukee County, that a new Board of Trustees be selected to take charge of this plan, and that these trustees be selected from all parts of the state in proportion to the physician population.

It is further decided that the central office of the new plan be in some area other than the cities where the offices of the two plans are now located, that all reserve funds now existing in the two plans be transferred to the new organization, that the contractual relationships of the subscribers to the present Milwaukee County Surgical Care Plan receive the whole protection of all their rights in the existing fund, that this be effected in accordance with the laws of the State of Wisconsin, the regulations of the Commissioner of Insurance. The Council further decides that a committee of six be formed, three of whom shall be selected by the President of the State Medical Society of Wisconsin, and three by the President of The Medical Society of Milwaukee County, and that this committee provide ways and means for the early selection of a Board of Trustees in accordance with the previous recommendation.

The Council fully appreciates that both societies have been actuated by the highest motives

of bringing all possible aid in their power through prepayment plans to the people of the State of Wisconsin.

The Council further decides that a new Executive Director be employed rather than employ either of the present directors of the plan.

End of the quotation that was stated in this letter to the membership. That is the total AMA recommendation.

The first step carrying out the Council's recommendation—I am again reading—has already been taken, that is, the appointment of a six-man committee. The doctors selected by the President of the State Medical Society of Wisconsin to serve on this committee are as follows: Dr. F. L. Weston, Madison, Dr. J. E. W. McGill, Superior, Dr. W. S. Bump, Rhinelander. Three physicians named by the President of The Medical Society of Milwaukee County are: Dr. A. C. Schmidt, Milwaukee, Dr. G. S. Flaherty, Milwaukee, Dr. N. G. Wegmann, Milwaukee.

The new committee held its first meeting at Madison on July 8 at which time the foundation was laid for a mutually cooperative effort on the part of the state and county societies to carry out the recommendations of the Council.

We firmly believe that through the efforts of this committee, the objectives for which we have all striven for so long will materialize, and we earnestly ask your continued forbearance and cooperation.

Now there is one more statement. What happened to those two committees? The only thing I have is a letter by Doctor Stovall on August 9, 1948, about a year or thirteen months later to Dr. Frank Weston.

Dear Doctor Weston:

For the past several weeks I have delayed replying to your letter of June 7 in which you asked for the discharge of the special committee appointed to devise a plan for combining the Milwaukee Surgical Plan with the State Medical Society's Physicians' Service for sickness insurance. This delay has been occasioned by disappointment at the failure of the committee to reach an agreement. I am sure Doctor Dawson will also be greatly disappointed. This disappointment is made still greater by your statement, "I still do not believe that this is a problem too difficult to solve, and I think that a total, impartial group could handle it very satisfactorily and very promptly to the satisfaction of both Milwaukee County and the state groups."

That is the end of the quotes from Doctor Weston's letter.

Doctor Stovall continues: Doctor Dawson provided the committee with three men who had no personal ambition and were entirely unbiased and unprejudiced in their approach to this problem. In spite of my disappointment, I am accepting your judgment, however, and discharging the state representatives of that committee. Thank you all for your sincere effort in trying to bring to a satisfactory conclusion a problem that has been the source of much conflict and dispute in the last few years.

I believe, sir, the Milwaukee committee has never been discharged.

Chairman Sorenson: Doctor Hollenbeck.

Doctor Hollenbeck: In bringing that up, it seems to me it is almost identical with this resolution number six, so here we would be starting where we were twelve years ago, starting almost exactly where we were twelve years ago.

Doctor Weston (Treasurer of the State Medical Society): Gentlemen, I have been back there keeping quiet, and I didn't know this was coming up. As stated in this letter, the state society appointed three people who were cold as far as this insurance problem was concerned. I had just gotten out of the service. Doctor Bump and Doctor McGill had not been in the realm of insurance, at least as far as I know. We assumed, and I believe it is still true, I believe it is true that Doctor Wegmann and Doctor Flaherty were also cold. Doctor Schmidt was an orthopedist, and they aren't ever out of the insurance problem, of course, so he had probably been in a good time, but be that as it may, we had our first meeting as you read, Doctor. And I can't discuss this in detail. It has been so long ago. My memory is getting bad, but I can remember a few things, and the first thing was that we felt as six men that we could take care of this situation for the society and for the Milwaukee County Society. We had our meetings, and we would arrive at certain conclusions.

All right, here is what happened. The Milwaukee group would go home, and within forty-eight hours I would hear from Doctor Schmidt that, no, that won't work. I think I am putting this quite factually.

All right, then we will have another meeting, and we would have another meeting in which we as six individuals would come to very definite agreement. Within forty-eight hours of the conclusion of that meeting, again I would hear from Milwaukee, from Doctor Schmidt, no, that won't work.

All right, then to make a long story short, I suggested that we as a committee of six, and I am sure that the state society group wanted to be a committee of six and not a committee of the state and of Milwaukee, let's us get the best legal talent we can to sit in with us and advise us on whether or not we are proceeding properly. That was fine.

All right, we said where will we get that legal talent, and how will we choose that legal talent. It was decided by the six of us that I should go to a member of the Supreme Court and ask him to give us either the name of the ablest insurance attorney in Wisconsin or in the nearby states or a number of attorneys who could be of help to us.

We were in agreement that this was a very satisfactory procedure, and we were all set to go ahead with it. The next morning I had a telephone call from Milwaukee from Doctor Schmidt in which he said that just won't work. It just won't work that way. What we had ought to do is to get an attorney for you and an attorney for us, and I said, "Doctor Schmidt, you are killing the whole object of this committee, that is, to work as a unit to solve this problem."

I said, "I will tell you what we will do. We will say to you that you get an attorney. You can get an attorney whom you feel is capable. We will ride along with you."

All right, that is fine. Two weeks later I called up Doctor Schmidt. What about that attorney? Well, we are working on it. Two weeks later I called up. What about that attorney? We are working on it. And I can't be accurate in this, but probably two more times I called up at longer intervals. They were still working on it. At the end of that time and close to the meeting of the Council, possibly the state meeting, I can't remember my dates, I wrote the letter which Doctor Stovall refers to, but which you do not have. I felt then that if there was honest effort on the part of the committee of six left alone, that the problem could have been solved. The state three never consulted any member of the state society, officers, administrative group or anything from the minute we were appointed. We discussed nothing with them. We didn't report to them after our meetings.

We assumed that we were a committee of six to do a job. It turned out, however, that the same was not true of at least all of the Milwaukee group. Therefore, I felt as spokesman for the state group that it would be better to discharge the committee because it was quite evident that it was not a committee working independently to do a job for the State of Wisconsin. Thank you.

Dr. W. D. Stovall (Madison): Mr. Chairman, may I speak. I remember very clearly the incidents surrounding these agreements. I am not clear in my memory about some of the detail, but at this meeting in Atlantic City we met with the chairman, Milwaukee County had representatives there, and the State Medical had representatives there. Doctor Dawson was ill at that time, and I took his place. After the decision of the Council of the State Medical Society, the two groups of us sat down together, and we agreed that we would have appointed from our various organizations, the state medical and the county of Milwaukee, three men who were not interested in the insurance plans in any way and never had been, that they would come into this organization uninfluenced by any prejudice whatsoever.

I took this information back to Doctor Dawson. I talked with him personally, and he came into Madison. He said he would be very glad to live by the agreement that I had with the Milwaukee group in Atlantic City, and so he proceeded to appoint the committee, the representatives of the state committee, that Doctor Weston talked to you about. The president of the county medical society, I presume, or whoever's duty it was, appointed three people from Milwaukee, and the group was divided constantly. If my memory is correct, the appointment—and you would have to look back at the record now because I am not just clear what this relation was—but the men who had been appointed by Milwaukee County were not entirely free of prejudice in favor of the Milwaukee plan.

Now whether they had ever had a position on any of the insurance work in Milwaukee, either sickness insurance or Blue Cross, I am not sure, but if my memory serves me right, one member from that committee appointed from the Milwaukee County Society either had previously or was at the time on the Board of Directors for the insurance plans.

That would have to be looked up and confirmed. I can't remember clearly, but if you will refer to my presidential address to the House of Delegates when I was coming in as president, you will find my reference to this letter from Doctor Weston and my comments on why they failed. It was a great disappointment to Doctor Dawson, and it was a great disappointment to me because I felt that the matter could be settled.

I think now the matter can be settled. I feel disturbed because of the position that the doctors themselves are in at the present time, and the confidence that the public has placed in you to conduct a fair and just sickness insurance and hospital insurance policy. Of course, you do not govern the hospital insurance policies, but as a matter of fact, you do not have to approve them under your own government, but your own organization, you do have to approve. I am disturbed about another thing, too, because I have been interested in the practice of medicine in Wisconsin ever since I landed here and before that. As a matter of fact, I have been interested in medicine almost ever since I can remember. But the thing that bothers me is why did Milwaukee County all of a sudden, when Blue Cross found itself in great difficulty with the State Medical Society on controversial administrative matters, suddenly decide to give Blue Cross the influence of Milwaukee Surgical Care outside of Milwaukee? You had been practicing in Milwaukee County and city and were confined to Milwaukee County for fifteen years, and you were doing well. You were apparently satisfied.

Now, were you frightened with something, and what frightened you, I don't know. Perhaps you got frightened at HIC, but I don't see why you should have been frightened at HIC. As soon as Blue Cross knew that they had Milwaukee's influence through Surgical Care, as soon as they knew that or very shortly thereafter, HIC died, and why did HIC die so quickly after Milwaukee Surgical Care allowed Blue Cross to sell their sickness insurance outside of Milwaukee County?

These are very urgent questions if we really want to settle this thing. I want to say to you this question can be settled by the doctors in Milwaukee County and the State Medical Society. This constant wrangling between individuals is nauseating, and the public has no interest in it. They want good sickness insurance. Milwaukee County got good sickness insurance through Milwaukee Surgical Care. The State of Wisconsin got good sickness insurance through the Wisconsin Physicians Service plan.

Why can't we get together? What is in the background? There is something in the background. There is something in the background either through personal enmities or jealousies, and the doctors are being sucked into this thing. (Applause)

I didn't expect to speak here today because I thought the subject was fairly well covered, but I've heard so much here today where I thought the story was being only partly told, that I could not remain silent when it came so close to my own administration. When I was president, and I was greatly honored by this Society, and I felt the honor and I still feel the honor, and I think it is a shame that we permit us to be hammered around in this fashion. I am going to say another thing while I am on my feet.

I think that the doctors' intelligence in this state is above the average intelligence, and I think it is as good in managerial matters as it is among the great administrators in this state who manage great industry. I don't think they have any supernatural powers. They know how to make money, but doctors know how to serve people. I don't mean to say that some of the administrators do not know how to serve people, too. I am casting no aspersions on those men, but we don't need them if we put our own house in order, and may I say, Mr. Chairman, one more thing.

All of this comparison of father and son isn't even relevant. All of this thing of talking about a county society having jurisdiction over the whole State of Wisconsin, superior to all the other counties in the state, and that was the inference, if not actually stated, is absurd and ridiculous. The peace of the world depends on the order created by law and agreement, and that is the reason why we are in such difficulty in international problems today. Without order there isn't a single person in this room who has any freedom. Single individuals cannot rule great policies and great groups of people. Those great groups of people lay down certain laws and policies and administrators see that they are carried out.

The county governments in the State of Wisconsin cannot supersede the state government of Wisconsin. They can add to what the state government does if they can do something better when the state government approves it, but they must have permission to do so. That is order. The whole universe is run by order. All natural phenomena occurs by order. One checking another, and we sit here and beat each other to pieces and butt our brains out on little personalities and great ambitions of a few people.

It is nonsense, gentlemen, just plain, ordinary, unadulterated nonsense, and we should not permit it. We should not allow it to happen, and I want to say another thing, and that is this, that you cannot set up two administrative bodies, I mean two policy-making bodies to control one administrative body. You are sure to wreck your administrative bodies and yourself to boot. We must have a united effort, and we must have one group of administrators who administer the affairs of the State Medical Society of Wisconsin, and the State Medical Society of Wisconsin must be dominant in the determination of policy and in the administration of sickness insurance. If that is not true and does not happen, we have lost all we have fought for the last many years in the great fight that we made against compulsory sickness insurance by the government.

Now these, in my mind, are pure, simple, unadulterated truths. They cannot be controverted or contradicted. I am sure. I have seen it happen where there have been set up two policy-making groups to dictate what an administrative crowd should be doing, and the administrative crowd trying to appease two bosses. It is impossible.

This job can be done, gentlemen, with men of good will who want to do it, and I advise that this House of Delegates see to it that this job is done and done by men of good will who want to do it, and that you will honor the profession and remain loyal to the public of the State of Wisconsin. Thank you very much. (Applause)

Chairman Sorenson: Back to the resolution. We have gotten way off. Is there anybody else?

Doctor Dessloch: May I have the privilege of reading the majority report into the record?

Chairman Sorenson: We did not have the minority report read, Doctor Dessloch.

Doctor Dessloch: It wasn't? Excerpts of it were.

Doctor Willson: One paragraph.

Chairman Sorenson: Do you want to read one paragraph?

Doctor Dessloch: He read the paragraph of ap-

proval of the plan. The majority report has a paragraph disapproving the plan.

Chairman Sorenson: I will let you read that paragraph. That is the end.

Doctor Dessloch: Mr. Chairman, my name is Dessloch. I was one of the men who signed this majority report, September 18, 1946. I think I am the only man left, and soon I hope I can also leave this type of thing. There are six exhibits, so will you excuse me for just one single moment.

The House of Delegates shall rescind—to take effect midnight, November 30, 1946—paragraph four of the resolution adopted on June 22, 1946, providing that "this House of Delegates approves the manner of establishment of the Surgical Care Plan of Milwaukee County."

Chairman Sorenson: Thank you, Doctor. Now is there anybody else who wants to speak on this resolution?

Doctor Clark (Janesville): I represent the Section on Radiology. I have found I drew this up yesterday and nobody has seen it, so I am the only fellow who is responsible for it.

It will be an anticlimax after Bill Stovall, but I think there is a fundamental consideration that has not been mentioned in all of this discussion. I think it is germane to the subject and is basic, and I would like to present it as a part of this whole discussion.

Chairman Sorenson: Doctor, is it on the resolution?

Doctor Clark: Yes, it has to do with this resolution and all the other resolutions, I think. May I read it, please.

Chairman Sorenson: If it doesn't take too long.

Doctor Clark: It will take about two to three minutes. I believe it would be well for us to raise our sights and widen the horizon of our thinking.

We, the medical profession of Wisconsin, might very well quit fighting among ourselves and combine forces against the AHA and its agent, Blue Cross, in their avowed attempt to control the practice of medicine through their devious schemes of including medical services such as x-ray, pathology, anesthesiology and so forth in hospital insurance in doctors' offices and hospitals and so forth. These are medical specialties and should be included in Blue Shield contracts as they are in some states, not in Blue Cross. There should be a distinct line of cleavage between insurance for medical services and hospital services, and this has not been mentioned today. The hospitals are the workshops of physicians, and we as physicians should be in control. There is no more reason for them to bill for the services of radiologists, pathologists, and anesthesiologists than for surgeons or internists' fees. If Blue Cross will not consent to discontinue coverage for medical services, then we should set up our own hospital plan, omitting those services and transferring them to Blue Shield contracts. I said that fifteen years ago, gentlemen. Also, I believe we have sufficient actuarial experience and know-how to cover office and home care which the hospitals are trying to work into right now, which would lower the cost, lower the need for hospitalization, and thus decrease the ever-mounting hospital costs which create the danger of pricing hospital insurance up out of the reach of those who need it most, making beds available without long waiting, and take off some of the pressure of building new hospitals at even greater cost per bed.

All of these would be of benefit to the ultimate consumer, the patient, who in the last analysis should receive our utmost consideration.

One side or the other in this fight may win a battle, but we as a medical profession may lose the war. We have a wise physician in the driver's seat in the American Medical Association. We are proud of Gunnar. Let him be proud of us.

We are members of an honorable and honored profession. Let us not drag our standards in the mire. Let's forget petty politics and act in a statesman like manner. Thank you, gentlemen. (Applause)

Chairman Sorenson: That is all the comment unless it is on the resolution directly.

Dr. R. A. Straughn (Madison): I should like to say just a few words because I don't feel that I have the authority or the capabilities of many of the previous speakers. However, it is apparent to me, as I am sure it is to many in this room, that unless we express our opinion before this Reference Committee, we may come out with a watered-down compromise. Compromises are beneficial. They are valuable.

In this resolution I believe the danger is that we will create a new body and we will start all over again. I shall not detail what you have just heard. You know perfectly well that we have been through this problem long before I came here, and it has been reviewed very well. Compromises, gentlemen, don't always result in the right action. If we are agreed that the State Medical Society must be the parent organization, the supreme body, then we must take that action, and I would recommend that this resolution either be modified—and I did not speak to the Dane County resolution—but I would at this time say it seems to me that is directly to the point, that we cannot simply throw over by resolution and create a new body that will suddenly come up with better answers. We have got to have more unity, yes, but not by compromises, for example, by the lay members. This has been spoken against before. You have to have continuity in creating this thing. It is going to be difficult enough to get men who are violently opposed to this as Doctor Stovall intimated for reasons which can only be inferred, but we must be able to come up with something that we can say, well, this isn't necessarily in agreement with every member of the state, but it will be a compromise to the end that it will be a deliberate conclusion.

That is why I would recommend this resolution be either modified or rejected in favor of the Dane County resolution.

Chairman Sorenson: You mean the Dane County resolution, Doctor?

Doctor Straughn: I beg your pardon.

Chairman Sorenson: That was your statement.

Doctor Straughn: In favor of the Dane County resolution.

Chairman Sorenson: Does anybody else want to speak to this resolution? Discussion cut off.

The next resolution is a resolution that you all heard this morning by your President, Jerry Fons. Do you want me to read that again? Is there any comment on it?

Doctor Strakosch: With deference to our esteemed President, I think his resolution would accomplish nothing more than procrastination which we have already gone through. His main emphasis, if I understand it, is we, the profession, have to keep control over our house, so what earthly good would it do to have advisers in if we have to make the decision anyway? I am opposed to this resolution for it would not accomplish what we are after. It would just postpone doomsday.

Chairman Sorenson: Anybody else?
(The meeting recessed at four-forty o'clock.)

SATURDAY EVENING SESSION

September 27, 1958

The meeting of the House of Delegates reconvened at nine-fifteen o'clock with Doctor Leahy, the Speaker of the House, presiding.

Speaker Leahy: The meeting will come to order, and we will have the report of the Credentials Committee, Doctor Lokvam.

Vice Speaker Lokvam: Mr. Speaker, the Committee on Credentials has verified the registration of fifty-three delegates and twelve alternate delegates entitled to vote at this session of the House of Delegates.

Also the Credentials Committee has been informed by the respective county medical societies of the appointment of the following to act as delegates for that society in place of the regular delegate and alternate who are unable to attend.

E. M. Dessloch, Crawford.
J. V. Bolger, Jr., Waukesha.
H. W. Carey, Grant.
M. L. Whalen, Rusk.

In addition, ten alternate delegates and four councilors have registered their attendance.

Mr. Speaker, I move that the attendance roll of delegates, alternate delegates and specially appointed delegates totalling sixty-five so compiled by the Credentials Committee be accepted as the official roll of this session of the House to stand for the entire session.

Speaker Leahy: You have heard the motion.

Doctor Hollenbeck: Second the motion.

Speaker Leahy: You have heard the motion made and seconded that we accept the report of the Credentials Committee. All in favor signify by saying "Aye"; opposed "No." It is carried.

The next report is the report of the Reference Committee with Doctor Sorenson, Doctor Gutzler, Doctor Mason, Doctor Picard and Doctor Willson as members.

Doctor Sorenson: The report of the Reference Committee on Resolutions, September 27, 1958.

The committee has studied the various resolutions and has the following recommendations:

(1) The Dane County resolution appears to have enough confusion and uncertainty in wording and questionable legality so as to question the wisdom of adopting it. Also, parts of this resolution are incorporated in a following resolution.

Doctors Fons' excellent suggestion of utilizing a lay committee to compromise the differences between the two Blue Shield plans does not seem essential at this time in view of the recommendation that follows.

The committee does accept and recommend that the resolution submitted by the Sixth Councilor District be adopted in the following modified form:

> WHEREAS, the differences of opinion as to the operation and administration of Blue Shield Medical-Surgical Care programs in Wisconsin have resulted in a jurisdictional and philosophical controversy, and have created confusion in the minds of the consuming medical public, and have further created a divided medical front among certain segments of the membership of the State Medical Society of Wisconsin; and
>
> WHEREAS, all physicians agree that it is their sacred obligation to foster, preserve and protect the dignity of the fundamental private relationship that has always existed between patient and physician; and
>
> WHEREAS, the medical profession in Wisconsin has pioneered in providing a medical-surgical care insurance program for the people of Wisconsin that both protects the interests of and engenders the relationships with the patient and the doctor, and
>
> WHEREAS, continued controversy can only lead to the ultimate destruction of, and the loss of confidence in such voluntary prepaid medical-surgical care plans:

NOW, THEREFORE, BE IT RESOLVED, that this House of Delegates of the State Medical Society of Wisconsin in special session assembled conclude by orderly vote that one parent Blue Shield Medical-Surgical Care plan be maintained, fostered, and operated by the State Medical Society of Wisconsin, and

BE IT FURTHER RESOLVED, that the House of Delegates, representing the entire house of medicine of the state, direct the Council to appoint a committee impartial, and geographically and numerically representative to compromise the differences between the two plans and report at the next annual meeting of the House of Delegates; and

BE IT FINALLY RESOLVED, that we reaffirm the principle that any component county medical society wishing to operate any prepaid medical care plan under the existing statutes of the State of Wisconsin may do so with the authorization of the parent State Medical Society of Wisconsin.

Mr. Speaker, I move this portion of the report be adopted.

Doctor Willson: I second the motion.

Doctor Dessloch: Mr. Speaker, may I ask is that the total report?

Speaker Leahy: That is the Sixth Councilor District report.

Doctor Dessloch: May I request that the entire report be read, and then we look back at it?

Speaker Leahy: It can't be done.

Is there any further discussion? This is relative to the Sixth Councilor District report as revised and accepted by the committee. Several resolutions were taken up by the Reference Committee at the same time. They would come under this one vote.

Doctor Garrison (Wisconsin Rapids): Is this open for discussion? Mr. Chairman, I am Councilor from the Ninth Councilor District, and Wood County. As I listen and read this somewhat emasculated resolution, not knowing what is going to follow, it strikes me that the sense of the resolution as presented and approved says that things are to continue precisely as they are with the exception that the Council is directed to dissolve the current Commission on Medical Care Plans and appoint another one.

If anything is going to come out of this meeting, towards a solution of our present problems, it hardly seems to me, gentlemen, that firing—not firing, but relieving the present commission of its—

Doctor Willson: Point of order! The speaker is making statements attributed to the Resolutions Committee which we did not say.

Doctor Garrison: I don't have a copy of your resolution. I have a copy of the resolution which was changed, and I interpret the reading that—

Doctor Willson: The interpretation is incorrect, sir.

Doctor Garrison: Be it further resolved that the House of Delegates, representing the entire house of medicine in the state direct the Council to appoint a new body—

Doctor Willson: No, the word is committee. That has been changed.

Doctor Garrison: Correct.

Doctor Willson: A committee impartial and geographically and numerically representative to compromise the differences between the two plans and to report at the next annual meeting of the House of Delegates.

Doctor Nordby: Mr. Chairman, as I understand this resolution, this committee sounds similar to that which was spoken of by Doctor Stovall and others this afternoon, which was appointed in 1946, I believe, or before, and from which a report has not been received as yet. (Laughter)

My concern is that we are only putting this off for another indefinite period and accomplishing nothing but mental gymnastics for this meeting we have held here.

Doctor Sorenson: Doctor, might I say you didn't hear the entire resolution. We have given them until the next regular meeting of the House.

Doctor Nordby. Yes, they were given one year in 1946, I believe.

Doctor Bernhart (Milwaukee): Mr. Speaker,—

Speaker Leahy: Before we have any further discussion, let's have a reading of the entire report.

Doctor McCann: Mr. Chairman, a point of order on that. I would like to make a motion we suspend the rules and hear the entire report before voting on it.

Speaker Leahy: That is the same thing, isn't it?

Doctor McCann: It is the same thing, but I think you have to vote on it, don't you?

You have already ruled once we can't hear the whole report.

Doctor Gearhart (Madison): I move we adjourn ten minutes for a caucus.

(A ten-minute recess was taken.)

Speaker Leahy: You have had your recess, and I trust you have given it thought. We will have a reading of the entire report as it is germane to the understanding of the entire resolution. Therefore, the entire report will be heard before discussion or action on the initial resolution. The chairman will read it.

Doctor Willson: Point of order! Is it permissible for that ruling to be made after the motions have been accepted?

Doctor Dessloch: Mr. Chairman, I move the motion be tabled until we hear the entire report.

Doctor Strakosch: I second the motion.

Speaker Leahy: That is not debatable. Question? May I have a vote on that.

All in favor signify by saying "Aye"; contrary. The "Ayes" appear to have it.

Doctor Sorenson: The Reference Committee approves Council recommendation number one as submitted.

The Reference Committee has considered recommendation number two of the Council and while it feels that some of the allegations can be questioned, it agrees with the desirability of the study as outlined with the addition that lay advisors representing the subscribing public also be included.

Your Reference Committee has considered Council recommendation number three as well as the resolution of the Sixth District. In view of what that resolution can accomplish in compromising the differences of the two Blue Shield plans, it has recommended that this be tabled until the next annual meeting to allow further consideration of its implications.

Your Reference Committee recommends approval of Council recommendation number four, except that the words "insurance department" be substituted in place of "public officials."

As to Council recommendation number five, your Reference Committee feels it cannot be considered because it is in conflict with requirements of the Constitution and Bylaws.

Your Reference Committee recommends that the statement of the Council regarding costs related to the current problem which has necessitated this special session of the House of Delegates be accepted.

Your Reference Committee has read the statement of policy submitted by the Council today and has no recommendation concerning it.

Doctor Willson: Mr. Speaker, I move the acceptance of the report.

Doctor Houghton (Milwaukee): I second the motion.

Speaker Leahy: The motion has been made and seconded that the report be accepted as read.

Doctor Bernhart: "Sarah" Bernhart of the house of medicine. I would like to speak again to the first resolution. I would like to reiterate my position to which I spoke at the Reference Committee.

I feel we came up here for a solution to the problem, that we are very much interested in a united front in the house of medicine. We are very much interested that any controversies which exist between Milwaukee, the State Medical Society and Blue Cross we will try to get out of the picture, and my solution is this—and I would like to reiterate—that we as Surgical Care of Milwaukee, we as the State Medical Society, representing their plan, WPS, should sell only medical-surgical insurance, and I think then, as a general principle of operation, a liaison committee be appointed, and I think we would resolve all the controversy that we have been in for many, many months.

I think this idea of companion plan—and I have talked all over the state and in Milwaukee—that it was very necessary, but in the last few weeks, as I said before, I have come to the conclusion that we do not need a companion plan. I think as long as our philosophies and ideologies so differ then let us sell our own package, let Blue Cross sell its own package, and I think we will get along very fine, and to you gentlemen, I would like to make this proposal. I would like to make that in the form of an amendment to that which has been presented by the Reference Committee. Thank you.

(The question was called for.)

Speaker Leahy: Any further discussion?

Doctor Gearhart: Mr. Chairman, are we voting now on just this last amendment?

(Calls of "No second.")

Speaker Leahy: On the whole report.

Doctor Gearhart: If there is no second to that, I would like to speak to the first part of the report.

The question has been brought up as to the legality of some of the resolutions that have been made. We have legal opinion here. I would like to ask if we can't get legal opinion now tonight as to the legality of the Dane resolution. I so ask.

Doctor Willson: Mr. Speaker, may I speak on that subject for the Reference Committee. We were asked that same question, and we were asked whether we should have Mr. Murphy, the attorney of the state, give his opinion, and whether we should have the attorneys of Surgical Care give their opinion. It appeared to us that we would then be establishing a court of law on technical legal features of which it was beyond our power and scope to cast judgment. Therefore, we accepted the opinion of Mr. Murphy that—I cannot quote Mr. Murphy's opinion—that it would be unfair. We accepted the idea that we should avoid this pitfall.

Speaker Leahy: Further discussion?

Doctor Nordby: Mr. Chairman, I would like to propose an amendment to the Sixth Councilor District resolution as amended, as changed by the Resolutions Committee, to have Surgical Care stop selling out of Milwaukee County and WPS to sell outside of Milwaukee County.

Doctor Strakosch: I will second that.

Speaker Leahy: Discussion on the amendment.

Doctor Dessloch: Mr. Speaker, I would like to respectfully ask the House to have this whole business mimeographed, and we recess until tomorrow morning.

(Cries of "No.")

Speaker Leahy: Is there any further discussion on this amendment?

Doctor Willson: Sir, a point of order. Under the present organization of Surgical Care, is it within the power of this assembly to direct Surgical Care's internal activities?

If the chair would rule on it. It is not subject to debate nor can any other discussion come up until it is solved.

Secretary Crownhart: Doctor Willson, for the benefit of the Secretary, would you restate what you mean by a point of order. Are you seeking an interpretation of the power of the State Medical Society, or are you raising a point of parliamentary procedure?

Doctor Willson: Point of parliamentary procedure as to whether the House has authority in this field.

Secretary Crownhart: Your Secretary is having great difficulty in restraining himself, but he is doing it.

I would have to advise the Speaker that the point raised by Doctor Willson is not a matter of parliamentary procedure and is not a point of order. It is a matter of inquiry as to corporate authority of the State Medical Society, and as parliamentarian in behalf of the Speaker, I would so advise him.

Speaker Leahy: The Speaker can rule that it is permissible for the House to take this action, which he has.

Doctor Collentine (Milwaukee): Mr. Speaker, I rise to a point of inquiry then. Will you tell us by what authority the House of Delegates can tell the Board of Directors of The Medical Society of Milwaukee County that they shall cease and desist from the selling of Surgical Care out in the state?

Secretary Crownhart: Mr. Speaker, that inquiry I can answer specifically and authoritatively. County medical societies in this state are corporations under Chapter 148 of the Wisconsin statutes, a law first enacted in 1841, subsequently amended but still in effect. Chapter 148 of the Wisconsin statutes provides that no county medical society can adopt a constitution, bylaws or regulations that are inconsistent with those of the State Medical Society of Wisconsin.

I should like to state further that I think it is preeminently clear that there is jurisdictional authority attached to a county medical society only for the area in which it is organized and for which it was chartered. A corporation which exceeds its corporate powers, subjects its total membership to lack of corporate protection.

The House of Delegates representing all county medical societies in this state has the clear and unqualified authority and responsibility to define the jurisdiction and the authority of a county medical society. Just as the federal government can say to the State of Wisconsin, you can enact laws, you can pursue certain objectives to the Mississippi River, to Lake Michigan, to the Illinois border, or to the northern part of the peninsula, but Wisconsin has no authority in Michigan. We are organized in the image of our country as a democratic organization, fifty-three county medical societies submitting under the constitution, the bylaws, and the regulations of the State Medical Society to the will of the majority.

If that principle does not stand, the principle of an organized medical society is completely at loss. What I have stated is so elementary and so fundamental to the organization of any democratic type of association that I think there would be no one who would question it either as a matter of fact or as a matter of law. (Applause)

Doctor Sullivan: Mr. Chairman, I would like to ask for a ten-minute recess.

Speaker Leahy: Ten-minute recess is granted.

Doctor Willson: Mr. Chairman, I rise to a point of order to clarify my previous motion.

I apologize to you, sir, for not being clear in the first place. I will read this statement which perhaps will clarify it. It is our contention that the Secretary's interpretation of this point of order is wrong. We in Milwaukee agree the authority of the State Medical Society is supreme in intramedical problems, but it does not apply to the matter of civil law or to statute.

Now Chapter 148 of the Wisconsin statutes confers upon any county medical society, including the Society of Milwaukee County, the legal right and power to establish in the state, and notice that please, in the state or in any county or counties therein a nonprofit plan for sickness care. That right and power of a county society is qualified only to the extent that any such plan must be established in a manner approved by the State Society, and, of course, there is no longer, nor for the last ten years, has there been any question about the fact that the State Society has approved the manner in which Milwaukee sickness care plan was established.

Therefore, the right and power of The Medical Society of Milwaukee County to operate a prepaid sickness care plan throughout the entire State of Wisconsin is one which is conferred upon the Milwaukee Society by law, and that lawful right may not be impaired or restricted by the actions of this prime corporation.

I quote to you from Paragraph 47 of Roberts' Rules of Order revised and in particular from the 1951 copyrighted edition.

> "No motion is in order that conflicts with the laws of the nation or state, and if such a motion is adopted by unanimous vote, it is null and void."

Based upon that provision of the body of rules which governs the deliberations of the Society, it is my view that the subject of State Society control of the internal operation of Surgical Care is out of order and no vote can be taken thereon. (Applause)

Mr. Speaker, there is to be no discussion. Ruling of the Chair must be made. Is that correct, Mr. Crownhart?

Secretary Crownhart: As I understand Doctor Willson's point of order, it is based upon his contention that approval of Surgical Care as an interim matter in 1946 constitutes approval without limitation as to the future and is not subject to any modification in any subsequent session of the House of Delegates.

Based upon that contention, he raises the point of order—

Doctor Willson: I think I said the House of Delegates could not take away from Milwaukee County Society a permission given to it by the legislature of the State of Wisconsin.

Secretary Crownhart: Are you speaking to the point of order?

Doctor Bernhart: No, sir, I am speaking for myself when I get an opportunity to speak.

Secretary Crownhart: The point of order raised by Doctor Willson is correct if the assumptions he states are correct. I do not as Secretary advise this organization that the assumptions which Doctor Willson states are correct. Therefore, I feel that this House of Delegates can instruct Milwaukee County to stay within the confines of its territorial jurisdiction. His assumptions that once having granted approval in 1946 for statewide operation, which was at a time when it was an interim approval, and there were other actions taken, Doctor Willson's point is that the House of Delegates cannot now, I think I am correct in this interpretation—cannot now redirect Milwaukee County in any other channel.

He bases that upon his contention as to the interpretation of Chapter 148, only a portion of which he read.

Another portion of Chapter 148, Doctor Willson, states that a county medical society may not adopt regulations inconsistent with those of the state medical society.

I think that is also pertinent information for all the delegates.

Doctor Willson: But the issue, sir, is whether this Society is superior to the legislature of the State of Wisconsin which has granted us this authority.

(Cries of "No.")

Secretary Crownhart: The Speaker asks whether it is his prerogative to take the point of order under consideration. That is the prerogative if he wishes to do so. I so advise him.

He can issue the ruling at such point as he makes his conclusion or reaches it.

Speaker Leahy: I think that that might be one way to save a lot of unnecessary discussion. Let us hold this up just temporarily. We will get you an opinion, and then we will pass that out to you. I think that is the safest way to handle it.

Personally, this is just my personal view, I would say that the State Medical Society must be right. I couldn't possibly see how they could be wrong just because back in 1946 under a different situation entirely, certain privileges were granted to Milwaukee County, which applied at that time, but probably at this time under different situations would not apply. I think it is perfectly right to wait, and let's get the thing straightened up right instead of jumping at conclusions.

Doctor Hamilton: Mr. Speaker, I move this body recess until such ruling is forthcoming.

Doctor Bernhart (Milwaukee): Mr. Speaker, I have asked for the privilege of the House.

Speaker Leahy: Yes, sir.

Doctor Bernhart: In deference to you, sir, I would like to clarify my position. During the previous recess—

Doctor Willson: Mr. Speaker, a motion to adjourn is not debatable.

Doctor Bernhart: Gentlemen, I would like to clarify my position which probably hasn't been clarified to some of you gentlemen.

We are here to resolve a controversy, and I say this, and I will reiterate again my motion that Surgical Care of Milwaukee, WPS of Wisconsin, should sell only a medical-surgical plan. Surgical Care to stay within the confines of the Milwaukee area, the WPS to serve the confines of the state. Blue Cross to sell hospital wherever they want to sell it. That is my motion, and I think as far as the rider of WPS hospital plan is concerned, that will obviate the rider of a hospital plan.

Furthermore, I would also suggest that Blue Shield would include in their medical-surgical plan radiology, pathology, anesthesiology, psychiatry and any allied sciences which may come under the medical services of the plan, and I again beg you, and I think this is the resolving of a problem where we can all be friends even with Blue Cross, and I ask for you gentlemen to support this motion.

Thank you.

Speaker Leahy: There will be a recess while we try to straighten up this question which was brought up by Doctor Willson.

Doctor Bernhart: Mr. Speaker, before the recess, I would like to make my motion clear, that Surgical Care will sell medical-surgical only, and whether they sell it themselves or with another agency, I don't care, but I think if Blue Cross is going to sell hospital, they will have to sell hospital alone.

(A short recess was taken.)

Speaker Leahy: The House will go back into session again, and during our short recess I have contacted Mr. Murphy. He will give you a report on the question. Mr. Murphy.

Mr. Murphy: Mr. Speaker and Gentlemen of the House: It is my understanding the Speaker has been asked by Doctor Collentine whether he, the Speaker, has the legal power to rule that Surgical Care or more properly The Medical Society of Milwaukee County, a corporation, must hereafter contain its operation within the confines of Milwaukee County.

Now such is my understanding of the question. If that is incorrect, I wish correction immediately.

Doctor Collentine: I must correct that question if we have to go back to the stenotypist's report. My question is: Does the House of Delegates have legal power to force the Board of Directors of The Medical Society of Milwaukee County to stop the sale of Surgical Care out in the state, not the Speaker, Mr. Murphy, the House.

Mr. Murphy: Not the Speaker, the House.

Well, I have obtained my information here from some written record. All right, that matter is perfectly consistent with what I have been working over with these gentlemen. That is one of policy for which there is ample authority in the statute. That authority is vested either in the House when it is in session or in the Council when the House is not in session.

There is ample precedent for that position under the identical statute because Chapter 148 has not been modified by the legislature since the summer of 1945. A predecessor House of Delegates disapproved the manner of operation of Surgical Care in 1946, and again in October of 1948. It has been done before. It was done under the same statute and under circumstances which satisfied the House that it was timely for it to act, and that it could act.

Doctor Collentine: Mr. Speaker, may I have the floor.

Mr. Speaker, I request the floor to discuss the amendment to the resolution of the Reference Committee.

Speaker Leahy: That will be in order.

Doctor Collentine: The amendment to the resolution of the Reference Committee is unacceptable to the delegation from Milwaukee County. The resolution as offered by the Reference Committee is acceptable. We are arguing on the basis of premises that have been presented differently to the delegation from Milwaukee than they have been presented to the Council, and apparently to those members of the House of Delegates from outside of Milwaukee County to whom I have spoken. If Wisconsin Physicians Service is not suffering by the sale of Surgical Care out in the state, why are we here? The Medical Society of Milwaukee County did not ask for a special meeting of the House of Delegates. The Medical Society of Milwaukee County was told that the Blue Cross had sold an alarming number of policies that have formerly been held by WPS.

I don't have the figures in front of me, but the figure is alarming. Delegates from other counties have been told that the number of policies sold by Blue Cross for HIC is a pittance. I am disturbed that the Board of Directors of The Medical Society of Milwaukee County has not presented its figures which I am sure if they had been presented to all of you would have convinced you that the Medical Society Board of Directors acted in the only way possible.

The State Medical Society has not answered the argument that Blue Cross is selling the pants off them which is true. I believe it is very germane to the issue at hand. Perhaps one way that can be settled is by six months of time, and that is why we feel that while a committee is deliberating upon the resolution offered by the Reference Committee, perhaps these things can shake down, and it will be more clear to you from out in the state and to us in Milwaukee County, whether the action of the Board of Directors of Milwaukee County was necessary.

Secretary Crownhart: Mr. Speaker, I feel I have an obligation to report to this House as your Secretary and General Manager, those facts concerning the raiding tactics of Blue Cross insofar as Wisconsin Physicians Service is concerned to the extent they are known and provable.

Exaggerated claims have been made, and the completely unethical and unusual approach has been taken of going to the public press and boasting on the part of Blue Cross of its success in its attempt to reduce Wisconsin Physicians Service to an organization of nonoperable size.

Gentlemen, those attacks go to the very heart of the movement of Blue Shield, of the operation of the State Medical Society for which I am responsible as General Manager. With this shoe on the foot of Surgical Care, the anguished cries emanating from the shores of Lake Michigan would be much more than I have issued in any special report to you.

In August of this year, Doctor Morton reported to the membership of Milwaukee County that Blue Cross, and I am using approximate figures, although I can give you the exact quote if you want it, that Blue Cross had installed or sold more than 30,000 people with the program appropriately known as HIC.

That statement was made by the Executive Vice President of Blue Cross during the same month. I have in my hands the financial report for Blue Cross as of July 31, 1958. Page 9 of that report is a summary of Blue Cross transactions including those of Surgical Care. It reports that in July, 1958, there was in effect a net of 834 subscribers sold to HIC. Now, I don't know by what magic 834 subscribers enrolled in HIC can become 30,000 in a report of Mr. Wheeler, and in a report of Doctor Morton. You know, or should know, that a formula is used to determine the number of total covered

people based on family contracts. The formula commonly in use in Wisconsin is 2.5. Every time you sell a family, you figure that you have two and one-half people covered. Eight hundred thirty-four contracts would be multiplied by two and one-half. Unless there is some magic achievement in this state, of which I am unaware, we cannot apply ten or fifteen or twenty dependents to every subscriber.

The Blue Cross official figures as of July 31, are 834 contracts. Now, we have analyzed as best we can do it, and as factually as we can do it, and not for the purpose of public acclaim, what has happened to our own plan.

We have lost—everything available through this week is a total of 22,000 contracts at the best. The total loss is 22,000 contracts, and some of those are to commercials. Some of those involve people who have moved out of the state and some of the normal losses that we might in any event anticipate.

We replaced a number of those contracts. We have now sold more than 19,000 subscribers with hospital cost protection. We are now writing a premium volume of one million and a half dollars.

I can report to this House of Delegates that we have received cancellation notices in bulk obviously mailed by Blue Cross representatives, sometimes ten or fifteen, with the word "cancelled" written across them. We cannot accept a cancellation of that character. We have entered into contract with these groups. He is an unverified word "cancelled." We have tried as rapidly as possible to contact these groups. We lack the massive sales power of Blue Cross, but won't forever. Any number of them have reported to us, "What do you mean, cancelled?"

"We sent our check on such-and-such a date to Blue Cross."

I have the legitimate inquiry to me, depending upon this House acting firmly and resolutely, where is the money to pay for installations which claim they still have our protection? Where is that money? We have lost the 22,000 contracts. We are regaining them. We will regain more of them. Some of them have been cancelled by such representations as were reported by Doctor Ekblad two weeks ago at a Council meeting where he said in his territory the Blue Cross representative had gone to people and stated that the arguments between Blue Cross and Blue Shield were now over, and that he was happy once again to say to the people in his area that he represented both Blue Cross and Blue Shield, and he had effected the mechanism of consolidated billing.

Gentlemen, you of the medical profession are guided in bulk by principles of medical ethics. They are high principles. I for my part, not a member of the Society, only an employee of it, am also guided by the canons of legal ethics. It would be unprincipled for me, as it would for you, to make exaggerated statements in the public press, and by public circular, where the facts are not so clear as they are claimed to be.

I assert that I have offered you concrete, indisputable evidence that the statements made early in August by both Mr. Wheeler of Blue Cross, Doctor Morton of The Medical Society of Milwaukee County, that we lost over 30,000 people to HIC, that those statements are proved to be erroneous, completely erroneous by the report of Blue Cross to the Board of Directors for July of this year.

The copy is here at the Speaker's desk available to any delegate.

This has been a rough 90 days. We are hurt by Surgical Care. We are hurt deeply by Surgical Care. We are hurt because in an area where Blue Shield has been used to identify the state's program for more than ten years, the Milwaukee County program comes in under the same symbol, and using the same trade name, and has offered it to our people and to our installations as though it were one and the same program.

I cannot believe that the membership of The Medical Society of Milwaukee County, were it to have all the facts in its possession, would condone the extent to which the efforts of the county medical society in its own county have been used to discredit and destroy a program that is state-wide.

Rough times, yes, but I can fight, and I can fight with facts. I make no allegations here, and I make none to you at any time, unless I can prove them from reliable sources. It is a complete misrepresentation to state that HIC had 30,000 contracts in effect July 31. It is proven by its own figures.

Now to what extent Surgical Care has raided the 22,000 contracts, I will agree with Doctor Willson or anyone else in Milwaukee, and I believe it was Doctor Collentine who made the statement that certainly we have been hurt by Surgical Care doing it. Certainly it has reduced our size if we are going to measure size solely by contracts. That is why this House is in session. That is why from this House I must learn the future course of the management of the affairs of our organization.

We have not gone into Milwaukee County. We have stopped at the river, as did General MacArthur. We are allowing Milwaukee County to fight us in the area of its own choosing, and we have recognized and stood firm to our concept that Blue Shield should be Blue Shield of every county medical society.

Believe me, gentlemen of the House, it is a strain. We have developed in the last two years the elimination of the fee schedule and the elimination of benefits determined by the class of service necessitated by the patient. It makes no difference to the patient that his major financial burden is in radiology and that it is minor so far as the surgical procedure is concerned. The patient has the total cost of a single illness with which to be concerned.

It makes no difference to him that his major cost is rendered as an in-hospital medical patient rather than as a surgical patient. Still his total bill is one to be paid.

Wisconsin Physicians Service under the direction of twenty-four commissioners whose integrity cannot be challenged here or anywhere, together with the Council has approved this program of developing a fee schedule which is administered and determined by the county medical society in which the plan is installed.

We have raised the Blue Shield banner to be one of Blue Shield of Eau Claire, Blue Shield of Kenosha, Blue Shield of Dane, Blue Shield of Racine, and so far as the State Society is concerned, it is rapidly and would much more rapidly if it were not for this disastrous and nonsensical program that is now going on, it is as rapidly as possible eliminating the "B" schedule from the state, and it hopes to eliminate all schedules from the sale.

We can quote. There is no magic about it. We can quote the identical schedules of Surgical Care. We can call them preferred. We can call them special. We can call them super-duper. We have endeavored as best we could as a sales force to refrain from an attack upon the quality, the stability or the propriety of the purchase of Surgical Care of Milwaukee.

We have instead offered the merits of our program in comparison with the merits of Milwaukee County's program.

I have said to my staff that if we believe, and we have been instructed to believe as we do, that Blue Shield is properly to be devised and determined within each county medical society, then that we do not possess and should not endeavor to destroy Surgical Care of Milwaukee. We are sister Blue Shield plans. I wish that Milwaukee County would give to the effort of the State Medical Society the support of a companion plan, working toward the same objective, not one to destroy the other, but one rather to support the other, both in unison, each following the mechanisms peculiar to its district, each following the dictates of the local medical community.

I have stood before this House perhaps too often on controversial matters, but the House of Delegates establishes principles. It meets ordinarily but once a year. The Council becomes the managing body, and I have the function and the responsibility and the total responsibility of carrying on your mandates in the areas affecting chiropractic, in the areas affecting public health legislation and many areas of community interest, even to Milwaukee County.

I plead here that Milwaukee County stand in support of the effort of the rest of the state, not in an effort to assist Blue Cross in what appears to be a planned program of either ruin or rule.

I say to you again the program of the State Medical Society of Wisconsin is the only one that has operated in 1958 in the black. We are in the black through the month of July. You can examine reports printed in Milwaukee Medical Times as to Surgical Care, and you can examine reports available as to Blue Cross of Wisconsin. Neither of them can lay claim to the distinction accorded our plan of being in the black.

I submit to you that when management by the Council, by the Commission on Medical Care Plans and by the staff, if you wish, in this period of emotional competitive activity produces for you a record of a plan remaining in the black against those that sharply show the red, you should be proud and Milwaukee should join in that pride that Wisconsin Physicians Service is a program to support, my friends, not to destroy. (Applause)

Dr. Robert Purtell (Milwaukee): Mr. Chairman, our hired Secretary has just recently completed a seventeen-minute speech, and I would request that if I am not through at twelve minutes, you will extend to me a few extra minutes.

Speaker Leahy: So ordered.

Doctor Purtell: Mr. Speaker, members of the House of Delegates: I am Dr. Robert Purtell from Milwaukee. I have been in the general practice of medicine for 26 years. I am still actively in the general practice of medicine.

For the past 18 years it has been my proud job to be on the Board of Directors of the Blue Cross Plan of Wisconsin. For the past 12 or 14 years I have been the First Vice President, and as such have been on the Executive Committee of the Blue Cross of Wisconsin.

I have lived through these dreadful 18 years of warfare in Wisconsin where a fratricidal strife has pitted doctor against doctor.

I have been a member of the House of Delegates here for the past 15 or 16 years. So I have lived through all of this gory war, and all of the things that were recounted this afternoon as memories and as brand-new information to some of you younger delegates, I knew about those things because I lived through them.

I have watched the physician membership of the Blue Cross Board during these past 18 years. There have been some mighty illustrious members of the Blue Cross Board. Some of them are here tonight. My good friend, Doctor McCary, Dr. George Forkin, Dr. Tim Howard, Dr. Carl Neidbold.

I won't mention any more, but they are all good, honorable members of the State Medical Society. During all these years of the physician representation on the Blue Cross Board, we have been treated more or less as stepchildren. The Council of the State Medical Society, or organized medicine as such, has never called upon us to ask us what was going on in the Blue Cross Board, what policies were

being initiated, what plans were afoot. Nobody seemed to care.

During the first six years of the Blue Cross existence, the State Medical Society, by default violated the enabling act in not certifying those MD members of the Blue Cross Board who needed to be certified.

Now it has been said by our Secretary on many occasions, at least several, that Blue Cross killed his brother George. Now it so happens that I have two dead brothers, and I don't know whether Blue Cross or Blue Shield or who it was took these men, but this much I do know, and I believe that the same Divine Providence in His Almighty Mercy took my two brothers, and I am pretty sure took our Secretary's brother—not Blue Cross.

Now why do I say that? I will tell you why. I will have to turn the clock back to 1937 and 1938 and 1939 during the developmental stage of Blue Cross. There aren't many living who lived through that stage continuously and uninterruptedly.

In 1937 the State Medical Society had a joint committee to study prepaid hospital care, and Dr. Stanley Seeger of Milwaukee was chairman of that committee, and he is now dead.

That committee went out of existence during those years, and there followed another committee of hospital people who studied the possibility of emulating our sister state, Minnesota, which was, I think, number three in the Blue Cross list, and there was a meeting at the Pfister Hotel in 1937, at which time the then Secretary of the State Medical Society and Mr. Dan Grady, who is now dead, of Portage, an attorney, came down and they talked that meeting to death. Nothing was accomplished.

So a second meeting was held, and at the second meeting they again came down, but order prevailed, and they did not talk that meeting to death. At that meeting the hospital people recommended to the committee working on this matter that they go ahead with the Blue Cross plan or a type of plan, they weren't even calling it Blue Cross, at that time.

Now Mr. Joe Nordby, who is still alive, will verify this. Mr. Joe Nordby at that time was the administrator of the Columbia Hospital. He later went on to become president of JHA. Mr. Joe Nordby was a very prominent Lutheran layman. He had just come to Milwaukee from St. Paul, and as such he knew somewhat about the Minnesota Blue Cross plan.

An invitation was extended to Mr. Nordby to visit with the Archbishop, Samuel Stritch, and he recounted this to me, that he was invited up to the Chancery and when he got up there, he didn't meet only Archbishop Samuel Stritch, who later became Cardinal, but every Catholic bishop in the State of Wisconsin was up there. They talked over this idea of prepaid hospital plan, and Mr. Nordby told me that he asked Archbishop Stritch if he would publicly come out in favor of such a plan.

Now the Secretary of the State Medical Society at that time had just returned from a $10,000 trip to Europe. Mr. Herman Ekern, the former Insurance Commissioner of the State of Wisconsin, had been employed by the State Medical Society and paid a $10,000 stipend for advising the state society. Between the two of them they had plans for forming what would have been a mutual insurance company to take care of prepaid hospital care.

The Catholic nuns, running the Catholic hospitals in the state, were advised that they could not and should not participate in a mutual insurance type of plan, so Archbishop Stritch of Milwaukee gave public approval, and it was published in the Milwaukee Journal. You can read it, approving the idea of a nonprofit Blue Cross type of hospital prepaid care, and thereafter with not much delay, this was in the fall of 1939, the corporate papers were filed with the county clerk in Milwaukee, and with the Secretary of State in Madison, and Blue Cross was born.

The first officers were Mr. Joe Nordby, President. I forget who the other officers were. All of a sudden the plans of Madison and our Secretary of the State Society and Mr. Ekern went flying out the window, and the center of control was in Milwaukee.

There began a personal family vendetta which has continued even unto tonight, and that is why we are here tonight because of a vendetta that was begun then and is continuing.

Now during the first six years of the Blue Cross Plan, the State Medical Society had enacted its so-called divorcement proceedings so Blue Cross, whatever progress it did make during those first six years, it made in spite of organized medicine not because of it.

Speaker Leahy: We are all enjoying your talk, if you will avoid personalities. That is agreed at this session. There will be no personalities.

Doctor Purtell: Mr. Chairman, the Executive Secretary of the Blue Cross Plan, Dr. Sam Morton's name was mentioned right before, and I think that I must in part of this recap mention a few names. I am deliberately trying to avoid names.

The 1946 meeting of the House of Delegates was recounted to you this afternoon, and in 1945 the Blue Cross had signed an agency agreement with the Surgical Care Plan of Milwaukee County. It was a two-page, simple, typewritten agency contract.

In the fall of 1946 the then Secretary of the State Society and other representatives came to Milwaukee and asked Blue Cross if they would not sign an agency agreement with the State Medical Society to sell WPS.

Now this was the infamous marriage of convenience and a few days later, within a week, Blue Cross entered into what it thought was a legitimate, bonafide contract with the State Medical Society.

From 1946 until 1957, for eleven years, as Director of the Blue Cross Plan, I observed Blue Cross selling Surgical Care and WPS side by side under rather similar agency contracts. Blue Cross had utterly no trouble with Surgical Care. We had nothing but warfare with WPS over the most infinitesimal, little items. Crises were common.

This crisis of 1957 in May was nothing new. We had had them before similar to it. We had a crisis over the renegotiation of the 1951–1954 contract. We had a crisis over the major medical contract. So crises with Blue Cross, Board of Directors, and the WPS Operating Committee were nothing new, but they all stemmed from Madison.

Now we come to May of 1957. Not a word has been said at this session as to why the policy-making body of the House of Delegates, of the House of Madison in Wisconsin, was by-passed in May of 1957.

I have asked several councilors why the delegates were not given the same information that was given over at the Athletic Club an hour after we adjourned. I was told by a few of the councilors that the delegates wouldn't understand it. At any rate, a major matter of policy was by-passed, and the councilors were given over to an hour and a half, or three-hour, tirade at which time truths, half-truths, and outright falsehoods were given to the councilors by our Secretary, and had I been a councilor, I think I would have voted just about as the councilor did.

Now you may want to know what falsehoods were told. Anybody can ask me when I am through. There was a falsehood read to you here this morning. The statement of the Council written by our Secretary. That is why we are here tonight. It is a personal vendetta, gentlemen, and the greatest contribution this Secretary could do to organized medicine in Wisconsin from 18 long years of intimate observation would be for him to resign.

(Cries of "Boo.")

Doctor Willson: Mr. Speaker, I have the official figures here of Blue Cross concerning the sale of HIC. Since that seems to be important, may I read them, sir.

In fact, I will write them on the board if there is chalk there.

This is when HIC started sales. This is week by week.

June 26, 7,250.
June 31, 14,105.
July 7, 19,305.
July 14, 25,070.
July 21, 27,127.

These are participants. These are people. They are groups, contracts, participants. I am just giving you the date, the total participants. This is when it started, June 20, 1958.

July 28, 30,833.
August 1, 31,637.
August 11, 32,295.
August 18, 32,556.

Subsequently, four of these groups have cancelled, and four have transferred to Surgical Care.

This, gentlemen, is what confronted the Director of The Medical Society of Milwaukee County which caused their alarm and said at least let's put Blue Shield out in the state, so you have a doctors' controlled plan rather than having a Blue Cross modified plan.

There has been no further sale of HIC since Surgical Care went out into the state after that date. Thank you, sir.

Doctor Mason (Sheboygan): Mr. Speaker, gentlemen, I think we should compose ourselves a little bit and act as a House of Delegates, and do away with this trying to pinpoint certain things and get on with our policy-making decisions. I have practiced medicine for 25 years, and I have been associated with the plan that originated and started back in 1933, and the Sheboygan County Medical Society put in a plan under the enabling law of 1935, in 1938, which Milwaukee put in in Pressed Steel in 1943.

I have been a member of this House of Delegates I don't know how many years, but it has been well over ten. I have been a member of the Commission on Medical Care Plans almost from its inception, and I had the privilege of serving on the National Blue Shield Commission for a period of I think two years.

I have been a member and president of our county society and so on, and I am only telling you these things to try to give you some understandings that I, too, know something of what has gone on in the past.

I just want to tell you that in all the time that I have been associated with our State Medical Society, I have had numerous differences of opinion, and I have voted "No," on many, many occasions, but never at any time was I treated other than as a gentleman with the finest cooperation, with the finest—I just don't know what words to use to express how good it has been in my relationship with Charlie Crownhart and the whole staff of the State Medical Society, and never in my entire tenure of all these years have I heard any of the type of vendetta that was brought on here tonight by Doctor Purtell. I regret it very much, but I just must get up and tell you, and for the press, to tell you that we have a wonderful Secretary.

I can pick up the phone and get any information I want right now. I can call our lawyers, call our accountants, anyone. No information has ever been withheld, and I want to tell this House of Delegates, that I have just got to get up and tell you that the things that were said before just "tain't" so. (Applause)

Doctor Dessloch: Mr. Speaker, Doctor Dessloch speaking at the moment as a delegate from Crawford County.

It becomes exceedingly difficult to be objective in this sort of a thing tonight. I have had a long, long session with the house of medicine, too, and those of you who know me know that I have had no personal ambitions other than that what is good for medicine.

I regret very much the attacks that were made on individuals. I regret very much the attacks that were made on our employed personnel, and I regret very much the attacks made as it concerns our consultants, but we can argue from now until doomsday on that sort of a thing and get nowhere.

I regret also that the Reference Committee couldn't see fit to come up with a concrete statement of fact, be it one way or another, but at least resolve our problem. This has not been done. We have returned ourselves to at least 1946 and probably before that, and we are not going to accomplish a single thing, so that I would like to offer an amendment.

WHEREAS, the State Medical Society of Wisconsin deplores the growing confusion in the public mind over the operation of two Blue Shield sickness care plans in the State of Wisconsin, culminating in recent charges and countercharges in the public press; and

WHEREAS, it is a primary obligation of the State Medical Society of Wisconsin to safeguard the health interests of the people of all areas of the State; and it thus has a direct responsibility for the quality of all sickness care plans offered to the people of Wisconsin; and

WHEREAS, Chapter 148, of the Wisconsin statutes specifically provides that all sickness care plans established in Wisconsin by the medical profession shall be subject to the continuing approval of the State Medical Society of Wisconsin, including any such plans as are established by a county medical society;

NOW, THEREFORE, BE IT RESOLVED, that the State Medical Society of Wisconsin, through its House of Delegates, in special session assembled, at Stevens Point, this 27th day of September, 1958, hereby adopts the following statement for providing sickness care plans for the people of the State:

1. A county medical society desiring to operate a sickness care plan under Chapter 148 of the Wisconsin statutes should limit its operations to the area of its membership; otherwise that county society becomes a purveyor of the professional services of non-member physicians, with a paramount commercial interest rather than a professional concern in the services provided outside its borders.

2. The State Medical Society alone should offer a program of sickness care statewide, since it alone has statewide membership, through which it can effectively administer its contracts.

BE IT FURTHER RESOLVED, in light of the above principles that this House takes the following actions:

1. Approves the statewide sickness care plans established and operated by the State Medical Society through its division, Wisconsin Physicians Service.

2. Disapproves the present manner of operation of Surgical Care of The Medical Society of Milwaukee County because it is conducted in a manner inconsistent with the above principles.

Mr. Speaker, I move this amendment with the suggestion that the Reference Committee go back into session and reconsider the entire job they have done.

Doctor McCann: I second the motion.

Dr. Dexter Witte (Milwaukee): Mr. Chairman, may I ask permission of the floor.

Mr. Chairman, fellow members, I am going to ask a favor of you doctors who know my wife. I beg of you, please do not tell her that I spoke tonight because I promised her after I got my ears pinned back the other night, that I would keep my mouth shut. Please don't give me away. I am not going to say much except to suggest that in considering this motion that is presently before you, that perhaps it would be well to sleep upon it. The hour is pretty late, and consider it tomorrow morning again in connection with the suggestions made by my alternate as delegate to AMA, his suggestion which I am not sure in talking to some of you during our frequent recesses—I am not sure that it was entirely understood, and I want to reemphasize that and suggest it again, that you take that home as a nightcap to sleep on tonight. His suggestion was basically this, that the Surgical Care has grown and developed as we all know into a big, successful plan. Even though it is now presently operating in the red, it has been a very big and successful plan. Our state plan, WPS, similarly has grown to be a big, successful plan, and is still operating in the black. In the beginning both of these plans had great help in their organization from Blue Cross and Blue Cross for its purpose has done a swell job. I carry Blue Cross myself. I hope they don't kick me out. There are thus three successful plans operating in the state, and we are now, in spite of the success of these three plans, we are now engaged in what is at times a rather bitter and always unfortunate controversy.

I am sure that Doctor Bernhart's suggestion would end that controversy if there was any way that the House of Delegates could implement that. I am sure that we could all go out of here arm in arm as friends and start a new era. I have been through too many arguments, too many fights. Everything that has been said here tonight, all day, I have heard said before in other words repeatedly, but we can, if we follow Doctor Bernhart's suggestion, we can leave as friends.

Now that suggestion basically is this. WPS has demonstrated that it can stand on its own feet independently and operate in the black. Blue Cross certainly with its organization can stand on its own feet and operate in the black, if there is no quarrel, and if it is given a pat on the back by the state and county. Surgical Care has matured, has grown from a little plan to a big plan and Surgical Care by the same token can stand on its own feet independently. It can operate successfully, continue its successful operation.

There is no need for Surgical Care to depend upon Blue Cross for its sales and administration work any more than there has been demonstrated to be a need for WPS to depend on Blue Cross, and if this House of Delegates could find some way to persuade the Milwaukee delegates—I don't mean coerce them, but to persuade them to stand on their own feet and operate their own plan as an independent plan, independent of the state, stand on their own feet and operate that plan just the same as WPS is operating on that plan; that isn't going to sink either WPS or Surgical Care, and it certainly isn't going to sink Blue Cross. Blue Cross can then go out in the state and say: "We have a hospital plan. The doctors have a medical-surgical care plan. Theirs is a good plan. Ours is a good plan." They do not have to have a package plan, and our fight, gentlemen, down at the bottom of it hinges upon the feeling that we have to be tied up and Doctor Bernhart's idea is that we don't have to be tied up.

I think we can have three separate plans and operate them. If we can only put that across, we can all leave in friendship and good fellowship and our fight can be over, ended with smiles on the part of everybody. I leave you that as my bedtime suggestion. Thank you. (Applause)

Doctor Dessloch: Mr. Speaker, I am Doctor Dessloch speaking as Chairman of the Commission on Medical Care Plans. What Doctor Witte just said, the State Medical Society and its Commission on Medical Care Plans agrees with one hundred percent, but it does not, cannot, and will not ever become operative because that is what we wanted to do. That is exactly what we wanted to do, and the record will show that the Wisconsin Physicians Service at no time ever defied that. We did never, and as a matter of fact, Earl Thayer, we had community advertising that we paid for ourselves up until a couple of months ago, how long ago, Earl?

Mr. Earl Thayer: March, April and May.

Doctor Dessloch: Through May, 1958, and we did not begin a hospital rider for sale of hospital contracts until Blue Cross boycotted us.

We wanted the companion plans. You will find in our statement from the Council that we consider the philosophy of Blue Cross ideal. We believe in free enterprise plans of insuring against the cost of the medical illness as Blue Cross does. We thought, and we have always thought that we who own and operate Wisconsin Physicians Service should have the opportunity to direct that program. Blue Cross never saw fit to let us do so.

We thought when our agency agreement terminated, that we could go out into the state, outside of Milwaukee County, and sell companion packages. Blue Cross said, "No. You cannot do that because it is double administrative cost, and hence we cannot do it because we have to consider the participants and try to sell them the cheapest product possible, and double administration is not the cheapest."

Gentlemen of the House, there are figures available from the beginning of our separate operation through August showing conclusively that we are operating our entire program administratively for $3,000 more than what we would have paid Blue Cross to do only a portion of our administrative cost. We would have paid Blue Cross for sales, building, collection and internal operations, and then we would have had to administer our own claims, do our own statistics and do the many other functions that we had to do—research and planning. Thus when we say to you that we stood on the premise that Blue Cross was raiding us in costs, we mean it. They were. They were raiding our treasury. They were not being realistic in their bargaining, and you cannot bargain when they finally say this is it or nothing.

Speaker Leahy: We would like to get a vote on this amendment. We have a motion and a second before the House, and it is not debatable. We should have a vote on it.

Doctor Dessloch: It isn't? Well, then the speaker just before me was out of order, too.

Speaker Leahy: I was just trying to clear it up.

Doctor Sullivan: Mr. Chairman, may I have the permission of the floor.

Speaker Leahy: We have a vote on this amendment first to accept the amendment, refer it back to the Reference Committee for reconsideration, and according to the regulations it is not debatable. May we have a vote on that?

All in favor signify by saying "Aye"; contrary. The "Ayes" have it.

Now we will adjourn until ten o'clock tomorrow morning, is that right?

Doctor Willson: Does the primary motion not have to be passed? This is an amendment.

Speaker Leahy: It does not have to be passed. It is referred back to the committee for reconsideration.

Doctor Strakosch: Mr. Speaker, may I have the privilege of the House to speak to the House?

Speaker Leahy: We are adjourned until nine o'clock.

(The meeting of the House of Delegates recessed at ten-twenty o'clock to go in to the meeting of the Reference Committee.)

SATURDAY EVENING SESSION

September 27, 1958

The Meeting of the Reference Committee of the State Medical Society of Wisconsin convened at ten-thirty-five o'clock with Doctor Sorenson, Chairman, presiding.

Chairman Sorenson: Gentlemen, let's come to order. The Milwaukee delegates are coming in. We will wait until they come in. It won't be but a minute.

They tell me we must have an open hearing on this tonight because the House is going to meet in the morning. I don't know when your Reference Committee will have a chance to work on it. I think the Reference Committee should resign as of now.

Doctor Willson: I think in all fairness, sir, when it was announced there would be no meeting until nine o'clock tomorrow morning, we should be given time to bring our delegates back.

Chairman Sorenson: All right, gentlemen. The Milwaukee delegation is here. Might I ask right now if there is anybody that has anything to say on any of the work that was done this afternoon? If not, we will consider the amendments that were offered tonight.

Doctor Dessloch: Mr. Chairman, I don't think the House should be completely satisfied that the Dane County resolution is illegal or has legal implications or anything else, and if you are going to begin from scratch, it is still in my opinion the only constructive thing that can come out of the House of Delegates. On the other hand, I don't care actually. I will accept the majority rule, and you know it, and everybody else knows it. Whatever the decision is of the Reference Committee, it should be decisive so that procrastination is no longer an item of the whole program, and that is what we have had for many years. Let's once and for all solve this thing so that there will be no more special sessions of the House and so forth and so on, so they can get on with the normal operations of our programs.

I am sure that as a House of Delegates acting on philosophy and principle, the Dane County resolution is not at all out of order and should be reconsidered if you reconsider all of the material presented to you at the first session of the House.

If you do not, then I certainly recommend to you and to the House that the amendment last introduced also comes within the realm of possibility for the House to act upon, so that that is a decisive opinion and a decisive action, and the whole problem will then be resolved.

I don't want to belabor this whole thing because we are full—those of us who are in this thing are full of a lot of things that have happened since 1940-something or other, 1943, and we can't recount all those things, but they are all germane to the solution now despite the fact that they can't be recounted.

I think the House has to act on principles. Remember that medicine has to remain free, and if it is shackled in any way, it isn't good for the people that you are serving, and the people you are serving are the people in your community.

I only want a decisive action from the House of Delegates at this time. I think everybody wants that. I don't think procrastination is in order any more, and I hope that there will be others who have a view.

Chairman Sorenson: Let's cut our talks as short as we can, boys. I am getting pretty tired, and I am sure a lot of the rest of you are.

Doctor Sullivan: Mr. Chairman, thank you for the privilege of the floor. I couldn't get it in the last meeting.

Now we have heard here tonight that all plans are doing well. WPS is doing well. Surgical Care is doing well. Blue Cross is doing well. What is the objection to a resolution as put out by the Sixth Councilor District which actually will do this? An impartial board will examine these things for the next six months. This thing has been going on now for eighteen years. Do we have to settle it tonight at twenty minutes to twelve? We are pushing too hard, gentlemen. I don't think we can ever come to a satisfactory conclusion tonight, and as long as these plans are doing well, everyone says they are making money, let's let them go for six months. I am sure by that time we from Milwaukee will know whether or not we are right or wrong.

Remember, Doctor Willson presented the figures of HIC. He showed you what prompted us to go out into the state. Maybe we are right. Maybe we are wrong. There is no reason to believe that we can't change our minds, but do you want us to change it tonight?

We haven't been presented with any testimony to the contrary. Give them a chance. If at the end of six months WPS proves to be the sturdy youngster we all have heard it to be, do you think for one minute Surgical Care wants to remain in the state? Don't be silly. I can't understand why you question our sincerity. Just what do we get out of it? Certainly if you can prove that WPS can stand on its own feet, and the way it is selling is the proper way to do it, we don't have to worry about HIC or any other insurance plan. We would be the first to get together with you and try to arrive at an amicable solution.

Doctor Witte's speech he gave once before to the Milwaukee County Medical Society. I am inclined to agree with him, that certainly we want to settle this thing. One thing we do want, though, is to be persuaded. We don't want to be forced, told off. A little persuasion and a little give and take, and certainly this thing can be settled, but I ask you gentlemen. Don't try to settle it too fast. Six months is not too long to wait. Thank you.

Chairman Sorenson: Might I right now ask the Milwaukee delegation if that is the feeling of the entire delegation?

Doctor Houghton: I believe I can say that is true.

Chairman Sorenson: For the entire delegation?

Doctor Houghton: Yes.

Doctor Overman: The interest that we have in our county is to have insurance for our people. We as a small country community have our hospitals in close association with the doctors. As far as any figures that are available today, I don't think they have meant anything. Many of us out in the country have said when people have asked us what to do, that they had better hold tight, that this thing isn't settled, so they have stayed with the program they have had so far.

I well realize that the doctors in Milwaukee County and those in the state at large should get together so that we aren't in battle. Milwaukee County, I believe, to settle this thing should have their plan in Milwaukee County alone. The committee should decide whether this should be done. If that is done and the rest of the state as a whole goes for the Wisconsin Physicians Service plan, there won't be any argument, and I still think we need the Blue Cross.

The Blue Cross is well established. Many people have a deep feeling toward it already. It is sold all over the country, and I don't think as a whole any of us doctors should be in the insurance business, because we are not in a position to have time to spend in the insurance business. We haven't the time to go out and take care of those things and carry on an active practice. I for one came over here, and I think we have wasted an awful lot of time listening to a lot of things that are irrelevant, and I would like to see us get down to something concrete where we can go home and having settled it correctly because many people are waiting for a decision from us. I don't think we should go and wait another six months. We know right now what we have to have, and I don't think another six months is going to help us one bit.

Doctor Satory: I feel that a delay of six months, as Doctor Sullivan just mentioned, would aggravate this condition and make it much worse at our next session. I have a few suggestions that I would like to present to the committee. I feel that WPS and Surgical Care should maintain status quo possibly as of January 1, 1958. That WPS and Surgical Care and not Blue Cross and Surgical Care should sell a common hospital contract along with their respective surgical-medical coverage. Since WPS has a sales force, WPS will assume the function of agent for Surgical Care regarding selling and other administrative functions which they have, which is now being done by Blue Cross for Surgical Care, with definite mutually agreeable contractual arrangements possibly controlled by a commission formed with representatives of both bodies.

Gentlemen, I assure you then and then only will we reunite in a manner presenting a common front in this problem, and we will find that probably after a year or so of that that Blue Cross will come seeking reaffiliation.

Doctor Garrison: I am the Councilor for the Ninth District. Mr. Chairman, Gentlemen: I would like to make two points. The first in relation to the suggestion of holding this in abeyance for six months. Incidentally, my name is Garrison from Wood County. I have been on the Commission on Medical Care Plans for about—well, since 1947, I think, and I also have lived through quite a bit of this. My interpretation of the effect of Doctor Sullivan's suggestion would be if I understand it, that for another six months we would continue as status quo with WPS, competing out in the state against a combination of Surgical Care and Blue Cross, and in the event that we aren't losing money at the end of six months, possibly that Milwaukee County, if we were successful, would then be in a position, would be inclined to reconsider and withdraw Surgical Care from the state.

Now, it doesn't do to speculate on what the effect would be of that, but I hardly think it would solve any problems between us, and even if it did prove that we lost money competing against a very strong but still minor segment of our State Medical Society, that even if we did lose money, it wouldn't prove that we were not right ideologically or from a business standpoint when we went into that program.

Now the second thing that impressed me is that at least on the surface Milwaukee County is in almost the same relationship to Blue Cross that we were in about 1954 when we were making our next to last negotiation, and the last successful negotiation so-called with Blue Cross, at any rate, when we went to twenty-one cents per contract, whatever date that was.

At that time and both before and after we were dissatisfied with the sales effort. This is fundamentally the only superficial difference at least. Currently Milwaukee is satisfied with the sales effort that has been put forth by Blue Cross in each instance. I have the impression that at least some people currently in Milwaukee were concerned about Blue Cross' termination of their contract with us, with Blue Cross possibly terminating their contract with Surgical Care, just along the same lines that we were confronted with the ultimatum in 1954 at which time we, of course, had no possibility of effective sales, so that we either took the .2130 per contract or as of the next week or so we no longer had a sales agency.

I think that Milwaukee County can take some comfort from the fact that WPS is now operating all right in spite of a number of unnecessary drags on our operation. We aren't doing as well as we should, but we are still doing all right, and they should take some cognizance of the fact that should anything like that happen to Surgical Care, as has been offered repeatedly, that the State Medical So-

ciety would certainly be standing by to take over what internal administration was necessary to keep Surgical Care on its feet. That has been implied. That has been implied in a good share of our conversations with Milwaukee County, but I think somebody else had to say it, and I am saying it right now.

Doctor Mason (Sheboygan): Mr. Chairman, I don't believe that we in six months will accomplish anything. I think we should arrive at a decision, and I think in arriving at a decision—

Chairman Sorenson: Doctor Mason, what do you mean by six months?

Doctor Mason (Sheboygan): You want to wait six months and give them a chance to see—

Chairman Sorenson: That was for the committee that was to be appointed to amalgamate these plans.

Doctor Mason: That is right, but in the meantime you have this competition going on. I would like to be realistic, and Milwaukee is here. They can correct me.

I don't believe that Surgical Care is going to stop selling throughout the State of Wisconsin. This is just my own opinion. I feel, and I deeply feel, that they probably have the philosophy that is somewhat similar to mine. Probably two "Blue" plans belong basically together. Maybe it is their own philosophy that they want to have the "Blue" plan selling with another "Blue" plan is fine. I am all for it.

Now when you do that, you use the symbol Blue Shield, and that implies that you have a full payment provision. I think in all fairness to the public and in all fairness to what you talked about when Doctor Sullivan was up here and others, that you have to give a little, take and compromise and so on.

I think that Surgical Care of Milwaukee County really believes in the basic philosophy of full payment with your Blue Shield plan and selling Blue Cross. That is wonderful, but to me you must be able to supply that medical service in the area where the people usually get their medical service. When you say that you have fifty percent, you are taking maybe all the doctors in Milwaukee County, maybe another eight hundred, technically you may be correct, but I don't believe, gentlemen, that you are correct when you say that if you have fifty percent, you can service your patients in Green Bay or Eau Claire or other places. If you really believe in your philosophy and you want to give and take, why don't you continue what you are doing in Milwaukee County, go ahead and sell outside of Milwaukee County if you think you have to protect yourself against HIC, but be fair to the public. Be fair to your state medical society and don't use that Blue Shield symbol, but sell it under a different name. The reason it is not fair is because you come in to these people—and I have had a lot of personal experience with this—the salesman comes in and converts them from WPS to Surgical Care, and the people do not know they are being converted. Blue Cross had all the records of WPS. They knew every group, every contract, every nongroup.

I want to ask Milwaukee County, do you think it is fair to the public, do you think it is fair to the state society to send your salesmen in and use the tactics they have and convert these people over without knowing they are being converted?

If you feel you have to sell, I think that this committee could come up with some sort of a resolution in which Milwaukee County now could form their board of directors, and they have a lot of their men here and give us an answer to that tomorrow morning. If WPS, under their setup of selling hospital indemnity with the Blue Shield service plan can't survive under fair competition, then we will find out.

We feel it can, and we feel that it is under unfair competition, but I would like to have an answer to that from Milwaukee County. I would like to suggest very seriously that that might be a solution rather than to bring in a very drastic solution that Milwaukee obviously doesn't want.

I don't think any of the doctors here want to do it either, but if you don't do something pretty soon, this just can't go on.

Dr. George Schwei (Menasha): I was one of the sponsors and co-authors of our Sixth District resolution which is before this committee. If as the delegates from Milwaukee suggested, that there be a cooling off or waiting period for six months as was suggested this afternoon, possibly a waiting period until the next annual meeting which would then be eight months, I can certainly envision what Milwaukee County may do. Is it not feasible Milwaukee County, that you could triple your sales force, undersell, compare our B plans to your superior A or preferred plan?

I would just like to know. I envision an awful brawl in competition with WPS because at the end of that six months we will have figures like this showing how much superior the Surgical Care of Milwaukee County has been, and the only way you can do it is triple, quadruple your sales force and undersell WPS. I do not believe in, and I am not in favor of a six to eight month waiting period.

Doctor McCann: Mr. Chairman, there is one point that I think everyone is aware of, and probably I have no reason for bringing it up, but there is one basic principle, one basic point that is important to the La Crosse County and every other county society that I think should go on the record.

When Surgical Care goes into a county other than Milwaukee County and starts selling, if any question comes up of whether their own plan is being sold, any other administrative question, anything like that, that the doctors of that county have a question about, they have no representation on your board.

As a result, if we are dissatisfied or any of the doctors are dissatisfied, for instance, if I were, I would call up your board and state what the point was. Somebody would say, "McCann, who is he? So what." As a result, we are left where no complaint can actually be followed through. On the other hand, when you have a state organization like WPS, if something like that comes up, then we can get hold of a representative and at least we can make it hot for him. So as I say, I am not bringing up anything new or anything that is strange to anybody here, but I do think it is well worth recognizing that if you are going to have a democratic organization, then you should have representation when one county goes into another county.

Secretary Crownhart: Doctor Sullivan used the term give and take, and most appropriately because the give has been applied to the State Society, and the take has been used by Milwaukee County.

We are charged in the operation of a Blue Shield program known as the doctors' plan. It has been identified in that fashion for many years and relates to the WPS. Dilatory tactics, delay, further opportunity of Milwaukee County and Blue Cross to capitalize on the same trade name can seriously jeopardize our program.

I know that Milwaukee County has lost in the neighborhood of $100,000 since the first of the year. I know that Milwaukee County has been advised weeks ago that its rates to subscribers must be increased. I know that Blue Cross of Wisconsin has lost slightly over $1,300,000 through August of this year. Is that the correct date, Don? Through July of this year. We know that the subscribers to those programs are inevitably confronted with an increased rate. We are told by our actuary that we must adhere to an annual rate that he has established.

If I can make this one plea to the committee, it is that it clear the decks for the State Medical Society of Wisconsin to operate its program unchallenged by a competitive Blue Shield device, unchallenged by a county medical society in all areas of the state except Milwaukee County.

I would regret—I am sure it will never come about—that we of the State Society would take our program into Milwaukee County. I think Milwaukee County could then recognize the havoc that it is creating for the State Society and the difficulty with which we are encountered when we have Blue Shield plans, our doctors' plans, offered with your professional endorsement.

Is it up to us to attack, to superanalyze, to destroy the effectiveness of Surgical Care of Milwaukee County? We have refrained from doing that. We have offered only what we felt was the competitive merit of the program, and we have lost installations on the raids.

Unless the Reference Committee and the House of Delegates states emphatically and clearly that Milwaukee County stay within its jurisdiction and stay away from being outside of Milwaukee County, then you are saying to us that for an indefinite period in the future we still are confronted with this most desperate of sales efforts on the part of Blue Cross.

Doctor Willson, I know not where you get your figures. I have here the report of Wisconsin Blue Cross Plan dated July, 1958. It reports on HIC as I stated and substantiates in no part the figures you have on the blackboard. I want to repeat and repeat and repeat that it cannot be a proud boast of Milwaukee that as a county medical society and with the use of the competitive device that it has that it is succeeding in taking contracts away from WPS. Give and take. What pride can there be in Milwaukee County that they have succeeded in taking away installations from the State Medical Society? What pride can there be in the county society which says, "We are effectively cooperating with Blue Cross which will not cooperate with you?"

There are days ahead, gentlemen, when cooler heads, calmer judgment and greater wisdom will prevail, and I predict if not in my day in someone's day that Blue Shield plans in Wisconsin will merge because the interest of the people will require the merger, and there must be unanimity of policy direction. Perhaps that will not come about. I hope it does. If it could be done today or tomorrow under effective leadership, I would be the first to endorse it.

I stand here as your general manager asking only that The Medical Society of Milwaukee County stay out of the State of Wisconsin, and I say here in that same statement my assurance is given to you that we will not invade Milwaukee County. During the hearing in May it was reported to your Reference Committee that you had the complete assurance of the President and the Executive Vice President of Blue Cross that they would not use HIC or any other insurance alliance against Surgical Care so long as Surgical Care permitted itself to be sold in Milwaukee County. By what reasoning can you enter the state to destroy the state society?

Doctor Sorenson, I ask of the committee only this, and of the House only this, that Blue Shield in seventy counties of Wisconsin be identified as the State Medical Society's program and only that, that the entrance of the county medical society into that area be forbidden by this House of Delegates, and that you take that action in final, definitive form that we may sweep the decks clear to assure the success and the maintenance of WPS.

Doctor Nordby: Mr. Chairman, I am wondering if as a point of inquiry we could have a legal opinion as to why the Dane County Medical Society's resolution was ruled to be illegal in the hearings as was reported. Could that be possible? Could we have that? That is what was reported.

Doctor Dessloch: That was reported in the report.

Doctor Nordby: Could I have that?

Doctor Dessloch: Do you have a copy of the report?

Doctor Nordby: We would like not to be suspected of trying to do something illegal.

Chairman Sorenson: Here is the report as it was written. The Dane County resolution appears to have enough confusion and uncertainty in wording and questionable legality so as to question the wisdom of adopting it.

Doctor Nordby: Could we have the question of illegality clarified by an attorney?

I don't believe Doctor Willson reported on that, did you, sir?

Doctor Willson: I didn't report on that, but Mr. Murphy did report in the committee when we discussed that.

Chairman Sorenson: Mr. Murphy, yes, reported to the committee. He did not say—where is Mr. Murphy. Mr. Murphy, will you come up and tell them what you said?

Mr. Murphy: I was asked specifically whether the amendment offered by Dane County presented special legal complications or might be of doubtful legality, and I was asked about the drafting of it. I said had I done the drafting, I might have drafted it differently. That is true of anything I see, but insofar as the legality of it was concerned, I was not troubled nor am I now.

The next question put to me by Doctor Willson was: Doesn't this run into chapter 148 permitting a county society to operate a county plan, and my answer was that the House of Delegates here, especially under the expansive theory that it is the all-important body, is quite free to direct a county society to enter into a county operation only through a specific kind of plan or slot, and this was an alternative way of proceeding because as drawn, the Dane County resolution calls for a state program with the ceding off or franchising to operate at a county level to county societies so requesting, and that is a different kind of a deal from the relatively greater flexibility possibly that is now permitted by statute. That is policy. I said that is policy. It is for the doctors to decide. It is not a matter of law or illegality.

Chairman Sorenson: Mr. Murphy, we did suggest that we have the attorney for the Milwaukee County Society come in, and we discussed the matter. We decided, or didn't you say that that would be a legal battle?

Mr. Murphy: I think I did, something to that effect. I don't remember any more.

Chairman Sorenson: They felt they didn't want a legal battle and hearing. Nothing could be accomplished, so the only thing we could do was what we did do.

Doctor Gearhart: If this is the case, and if we don't want a legal battle, may I ask that your job tonight is to try to get the expression of the men as delegates here to help you solve your problem. Is that correct?

Chairman Sorenson: Yes, that is.

Doctor Gearhart: I would like then to say I believe for our delegation that we would like not to delay six months or eight months, but that we would like to have some concrete settlement now, and we don't believe that if we are honest, when all of us on both sides say that we should consider the welfare of the patient as the prime objective, that it is going to be for the welfare of the patient to delay six months, and, therefore, we would like to have some concrete settlement now rather than a delay of six or eight months.

Chairman Sorenson: As to the legal matter?

Doctor Gearhart: Not only the legal matter, but as to the resolution of the whole problem, and that is what your committee is meeting for tonight, to give us something concrete which can settle the problem for which we came here this week end, not only to give us a legal opinion on it, but to give us something concrete to vote on to settle this.

I believe that is what the other delegates who have talked here have said also. I would like to second that, that we want something that will resolve our problem here and now.

Chairman Sorenson: You want that tonight, not tomorrow?

Doctor Gearhart: Tomorrow. (Laughter)

Doctor Strakosch: Mr. Chairman, the purpose of bringing our resolution in was, as I stated before, not to give you a blueprint but to give you a rallying point around which to work. Your Reference Committee in its infinite wisdom felt it necessary to strike out the one paragraph next to the last.

I don't see where the six months comes in. The Dane County delegation then amended it by stating, if I recall their amendment correctly, that in this period in which this committee reviews the whole plan, Milwaukee County would consent or would stay within its border. Now this is the compromise of a compromise. This would give a cooling off period to everyone. It would put Milwaukee temporarily back where it belongs. It would give the committee a chance to come up with something and maybe by the next time we have grown more gray hair and a little more wisdom and a cooler judgment and may come up with a final solution.

Doctor Waldkirch: I, as you know, helped to formulate the resolution introduced by the Sixth Councilor District. If I interpret the feeling correctly, Mr. Chairman, of the delegates of the House, at least of the delegates from outside of Milwaukee County, I believe that they feel that Milwaukee County would use this period between now and the next regular House meeting to procrastinate further.

I am willing to repudiate my participation in our own resolution if I would think for one minute that that is what we would use this time for. I believe that all the delegates outside of Milwaukee County would like to see your committee put some teeth into the solution that we arrive at today, and I agree with them. I believe that the first thing Milwaukee County and Surgical Care would have to do to show that they are men of good will and that they are trying to cooperate would be to immediately voluntarily go back to selling only in Milwaukee County, and if their selling agent, Blue Cross, would not agree to that, then it would be up to them immediately to drop their affiliation with Blue Cross and to come back to their home and join with WPS of Wisconsin and let us sell their policies in Milwaukee County for them or set up a sales force for them and sell in their own county. That I think would be a prerequisite, and I think that your committee should come up with some kind of a time limit of thirty days or sixty days in which they would have to show their good will by withdrawing back into their own county. I am sure that all of us who formulated the plan meant that this committee which we suggested be set up would be very, very carefully drawn, would have as its members only men that we all could rely upon, men of ability and integrity, and that they would bring about these things in a voluntary manner without coercion and without force.

That was our hope, but it seems that the rest of the delegates from around the state insist that there be some assurance, some assurance with teeth in it, that this would happen. I am sure that in their present mood they are ready and they are about to enforce their will upon Milwaukee County if Milwaukee County doesn't do it voluntarily. It is something I hate to see happen because the scars of such a conflict take a long time to heal. The bad thing about waiting another six months is that the public is confused for another six months. They are confused by competing salesmen. They are confused by untruths and—

Chairman Sorenson: Doctor: let's cut it short. That has been said so many times today.

Doctor Waldkirch: Okay, well, I think I have put my thoughts across.

Doctor Straughn (Madison): Gentlemen, perhaps this problem has been approached a little bit from the wrong point of view. We have the Secretary of the State Medical Society. He has made it absolutely clear what he recommends. He has studied this problem. I know there are those who say this means nothing. You heard his speech on that. I say to you that we do not have to claim any protection for men like that.

I charge that tonight we have seen stalling tactics.

Doctor Willson, I make no great accusation except that your standing on legality doesn't fit the facts. We have attorneys for this. If this Dane County resolution is so out of legality, let's pass it, and then see how legal it is.

We are not here to quibble with the law.

Now, gentlemen, I think our approach has been wrong. Most of us here have shown by sentiment that we want to get along with Milwaukee County, but I ask you in fairness, have they shown any real interest in being sincere and making a compromise? I don't think so, and I don't think many of the delegates do.

If the General Secretary recommends this, and he is sincere about it, I think the burden of proof must be on those who want to water it down and compromise it.

I again say to you gentlemen let's beware of compromise. Let's have done with and pass something. We can change it, but are we going to stand here and debate over something that is simple, and it is direct?

To you of the Reference Committee, I beg of you take some action. The House will approve or disapprove, and we will respect your judgment.

Doctor Collentine (Milwaukee): Mr. Chairman, it is regrettable that there has been so much wonderful oratory on a question that will probably be decided by a vote of 57 to 24. It is obvious that it is the will of the majority of the House that Surgical Care should withdraw into Milwaukee County, and WPS should exist in the state, or there should be only one plan in which both are merged.

There is only one course of action open to the House of Delegates, and that is to pass the resolution to that effect, and then it will be up to the Board of Directors of The Medical Society of Milwaukee County to take that action into consideration and to proceed as it is legally authorized to do independently, but cognizant of the will of the majority of the State Medical Society. (Applause)

Doctor Hildebrand (President-Elect): I, too, feel that the procrastination will get us nowhere. Your committee, Doctor Sorenson, tabled recommendation three of the Council's recommendations to this House which if passed would solve this entire problem. May I have permission to read this again, Doctor Sorenson?

Chairman Sorenson: Number three, yes.

Doctor Hildebrand: Every county medical society is directed to amend its bylaws to the end that it will conduct no functioning operation within the territorial jurisdiction of another county medical society unless with the formal consent of that society and with the approval of the State Medical Society.

If this is not voluntarily accomplished and made effective by the end of 1958, and retroactive as to any existing program in violation of territorial jurisdiction, the Council will, under the provisions of Chapter VI, Section 4, recommend to the 1959 session of the House of Delegates that the charter of such county medical society be forthwith revoked

and immediate efforts made to reorganize such county society so that it conforms to Chapter 148 of the Wisconsin Statutes.

The Council will, prior to making any such recommendation to the House of Delegates, conduct conferences or call special meetings with members of such county medical societies to the end that democratic membership activity may supplant autocratic officialdom, if such appears necessary.

Doctor Sorenson and your committee, that is all you need for action.

Chairman Sorenson: Anybody else? Anybody else on the amendment to the Dane County resolution as proposed by the Dane County delegates? That resolution or that amendment reads: I move that the motion be amended to have Surgical Care stop selling outside of Milwaukee County and to have WPS sell only outside of Milwaukee County.

Doctor Collentine: Do you mean the Dane County resolution or the Sixth Councilor resolution?

Chairman Sorenson: An amendment to the Sixth Councilor resolution.

Doctor Collentine: As revised by the Reference Committee.

Chairman Sorenson: Wait a minute, this is an amendment to the Reference Committee report.

Doctor Dessloch: Mr. Chairman, may I have just one word. I think Doctor Hildebrand is entirely right. That is the simplest method of solving this thing now and forever. There is no question of legality. It would stand perusal by the courts, and I don't think anybody wants to do something beyond the scope of the State Medical Society anyway, and if I can only commend to you, to the Reference Committee, that that be done, then we are all done and we can go home. I had two hours sleep last night and not much tonight and I am going home. Good-by. I won't talk again. (Applause)

Chairman Sorenson: Gentlemen, anybody else?

Do you want to state any motion, Doctor Dessloch? You presented a motion to the House.

Doctor Dessloch: That was only an alternative amendment, too, it does pretty much the same thing that the Council's number three does. I will stand on the Council's recommendation and you can scuttle this last one.

Chairman Sorenson: We are recessed.

(The meeting recessed at eleven thirty-five o'clock.)

SUNDAY MORNING SESSION

September 28, 1958

The House of Delegates of the State Medical Society of Wisconsin convened at nine-thirty o'clock with the Speaker, Doctor Leahy, presiding.

Speaker Leahy: The meeting will come to order. While we are waiting for our attendance report to come in we have a majority here. We can start. We will give you the report of the Credentials Committee a little later. That will expedite matters a bit and get you started.

I will turn the chair over to the Vice Speaker, Doctor Lokvam.

Vice Speaker Lokvam: Thank you, Mr. Speaker. The report of the Reference Committee on resolutions will now be heard. Doctor Sorenson, Chairman.

Doctor Sorenson: You all look bright and shiny this morning. I hope you all feel that way.

Your Reference Committee at the request of the House of Delegates had further hearings and studied the testimony submitted to it and has the following recommendations:

(1) That the Dane County resolution be adopted.

(2) That the resolution submitted by the Sixth Councilor District, and its amendment by Doctor Nordby, not be adopted since the material is adequately covered by the foregoing resolutions and the recommendations of the Council.

(3) Doctor Fons' excellent suggestion of utilizing a lay committee to compromise the differences between the two Blue Shield plans does not seem essential at this time in view of the recommendations above.

(4) The Reference Committee has studied the recommendations of the Council and recommends approval by the House of number one as submitted.

(5) The Reference Committee has considered recommendation number two of the Council, and while it feels that some of the allegations can be questioned, it agrees with the desirability of the study as outlined with the addition that lay advisors representing the subscribing public also be included.

(6) Your Reference Committee has considered Council recommendation number three and recommends its adoption.

(7) Your Reference Committee recommends approval of Council recommendation number four except that the words, "insurance department," be inserted in place of "public officials."

(8) As to Council recommendation number five, the Reference Committee feels it cannot be

considered because it is in conflict with the constitution and bylaws.

(9) Your Reference Committee recommends that the statement of the Council regarding costs related to the current problem which has necessitated this special session of the House of Delegates be accepted.

(10) Your Reference Committee has read the statement of policy submitted by the Council yesterday and has no recommendation concerning it.

Mr. Speaker, I move adoption of this report.

Vice Speaker Lokvam: You have heard the reading of the report of the Reference Committee and a motion for its adoption. Do I hear a second?

Doctor Picard: I second the motion.

Vice Speaker Lokvam: There has been a motion made and seconded. Is there discussion?

Doctor Willson: I would like to give a minority report of the Reference Committee.

Vice Speaker Lokvam: Doctor Willson, we will receive the report.

Doctor Willson: Mr. Speaker, members of this House of Delegates: The Milwaukee delegates came to this meeting with a sincere hope that a conciliation of the differences between us could be achieved. Milwaukee has said that it does not wish to be a dominant Blue Shield plan, yet Milwaukee knows that it is in the public interest, and that it was proper to expand its operations in the state when and as it did in the public interest, and we do not retract that.

When the compromise resolution of the Sixth Councilor District was submitted to this House and modified in the Reference Committee, that report was not entirely satisfactory to the Milwaukee delegation. There were many loopholes in that, but we accepted the fact that the Council could appoint men who could study this problem with the idea of coming up with specific recommendations at the next meeting of the House of Delegates and that we would have facts on which we could have real honest opinion.

Up to that point, and I wish to commend my colleagues on the Reference Committee. Up to that point this House of Delegates was participating in what would be called medical statesmanship. Since then it has not. The pressures on this committee of those of you who were here last night were such that the committee had no alternative but to come back. We are beyond the point where logic and reason are leading to conclusions as to what this House should do. There is an emotional situation.

Gentlemen, what you are doing, you are out for blood. The Machiavellian villifications of Madison are finally bearing fruit. This is the minority report.

Both the resolution introduced by the Dane County Medical Society delegates and the recommendation number three of the Council have as their purpose the establishment by this House of Delegates of one prepaid medical care plan to serve the State of Wisconsin under the direction of the House of Delegates of the State Medical Society. Such a purpose is without the power of this House of Delegates and both the Dane County resolution and recommendation are out of order because they conflict with the laws of the State of Wisconsin.

Chapter 148 of the Wisconsin Statutes confers upon any county medical society, including The Medical Society of Milwaukee County, the legal right, and power, to establish in the state, or in any county or counties therein, a nonprofit plan for sickness care. That right and power of a county society is qualified only to the extent that any such plan must be established in manner approved by the state society and, of course, there is no longer nor for the last ten years has there been any question about the fact that the state society has approved the manner in which the Milwaukee society's sickness care plan was established. Therefore, the right and power of The Medical Society of Milwaukee County to operate a prepaid sickness care plan throughout the entire State of Wisconsin is one which is conferred upon the Milwaukee society by law and that lawful right may not be impaired or restricted by the actions of this private corporation. This is in conformity with paragraph number 47 of Roberts' Rules of Order, revised, and in particular from the 1951 copyrighted edition:

> (Roberts' Rules of Order, paragraph 47)
> "No motion is in order that conflicts with the laws of the nation, or state, . . . and if such a motion is adopted, even by a unanimous vote, it is null and void."

Based upon that provision of the body of rules which governs the deliberations of this Society, it is my view that the resolution proposed by the Dane County delegates and the Council recommendation number three must be ruled out of order and no vote thereon should be taken.

Doctor Collentine: Mr. Speaker, I apologize for not having with me, and apparently with any of the other delegates, copies of the Dane County resolution and of the recommendation of the Council. I ask that if copies are not available to be given to us, that they be read.

Vice Speaker Lokvam: Does the Dane County delegation have several copies? There is a motion before the House which was presented by the Chairman of the Reference Committee. That motion has been made and seconded. Is there any further discussion?

Dr. Nordby: Mr. Chairman, I request a roll call vote, please.

Vice Speaker Lokvam: A roll call vote has been requested. There has been no motion as I understand of the so-called minority report. Am I correct?

(The question was called for.)

Vice Speaker Lokvam: The question then is the adoption of the majority report as presented by Doctor Sorenson, the Chairman of the Reference Committee. The Secretary will call the roll. Before you do, may I give you the report of the Credentials Committee.

The registration is sixty-two delegates and eighteen alternate delegates are entitled to vote at this session of the House of Delegates. Also, the Credentials Committee has been informed by the respective county medical societies of the appointment of the following to act as the delegate for that county society in the place of the regular delegate and the alternates who are unable to attend. They are Dessloch of Crawford, Whalen of Rusk, Bolger of Waukesha and Carey of Grant.

I move that the attendance roll of delegates, alternate delegates, especially appointed delegates totalling 80, so compiled by the Credentials Committee be accepted as the official roll of this session of the House to stand for the entire session.

Dr. R. W. Quandt (Jefferson): I second the motion.

Doctor Sorenson: I forgot to register.

Doctor Collentine: Before the roll is called, I respectfully request that at least the resolution of Dane County and the recommendations of the Council that have been favored by the Reference Committee be read.

(The question was called for.)

Vice Speaker Lokvam: The question has been called for.

Doctor Hildebrand: He has the right to have it read before the vote.

Vice Speaker Lokvam: Who has a copy? The resolution referred to by the Reference Committee presented by the Dane County delegates is as follows in its entirety:

WHEREAS, considerable effort to arbitrate the differences between Surgical Care of The Medical Society of Milwaukee County and Wisconsin Physicians Service of the State Medical Society of Wisconsin has failed, and

WHEREAS, the effect of these differences has been to confuse the patient, the hospital, the physician and others in a manner detrimental to both plans, and

WHEREAS, research continuing the pioneering efforts of Blue Shield is vital to the cause of prepaid medical care as indicated by the successful pilot study of the "No Fee Schedule Plan," which is expected to replace to an appreciable degree plans predicated on fixed benefits, and

WHEREAS, successful operation of a prepaid medical care plan of the "No Fee Schedule" order is predicated upon the ability to accommodate such plan to variable local circumstances, and such accommodation can only be achieved by the administrative direction of the concerned constituent medical society of the State Medical Society of Wisconsin in an anticipated progressively increasing exercise of "home rule;"

NOW, THEREFORE, BE IT RESOLVED

1. That this House of Delegates at this meeting establish by vote one Blue Shield Plan to serve the State of Wisconsin under the direction of the House of Delegates of the State Medical Society of Wisconsin, and

2. That in deference to "home rule," any county society unit may operate a branch of the mother plan within that county society's geographical limits and under the direction of the majority of the physicians practicing within those geographic limits, and

3. That exclusive franchise to represent Blue Shield in any geographic area shall be granted at the discretion of the House of Delegates of the State Medical Society of Wisconsin.

Mr. Secretary, will you call the roll.

Doctor Collentine: Mr. Speaker, I am sorry, but the report of the Reference Committee includes some resolutions or recommendations of the Council.

Vice Speaker Lokvam: That is correct.

Doctor Collentine: And I asked that those that are favored by the Reference Committee, and which will be implemented by passage of the resolution before the House right now, I ask that they be read.

Vice Speaker Lokvam: The other recommendations by the Reference Committee?

Doctor Collentine: By the Council—favored by the Reference Committee.

Vice Speaker Lokvam: They have been read. Your Chairman has read them.

Doctor Collentine: I would like to have them read.

Vice Speaker Lokvam: Number one refers to the Dane County resolution. Number two refers to the Sixth Council.

Doctor Collentine: Mr. Speaker, certain recommendations of the Council were favored by the Reference Committee. Certain were not. We would like to hear those that were favored.

Vice Speaker Lokvam: That were favored or not favored?

Doctor Collentine: That were favored by the Council.

Vice Speaker Lokvam: Is that available? Will you read them?

Secretary Crownhart: The Reference Committee recommends approval by the House of report number one which reads:

In a special report to the House of Delegates in 1938 of the Special Committee to Study Hospital Insurance, upon which there were physicians, hospital administrators, and others, the House received and approved a statement that *"a hospital insurance plan is and properly should be subject to the regulation of the insurance department of the state. The thousands of people who will pay into a group hospital fund, in expectation of receiving hospital care if sick, are as much entitled to protection by the state as are persons who pay premiums to an insurance company in the expectation of receiving any other indemnity in case of loss, depending upon the type of insurance. The welfare of a great mass of people is no different in either case."*

In the initiation of hospital service plans and of medical service plans the plea was made that they be exempt from virtually all insurance department supervision. Such was not the position of the State Medical Society of Wisconsin. Such plea, however, was accepted by the Wisconsin Legislature.

The development and acceptance of voluntary health plans in Wisconsin during the past decade has been little short of phenomenal. The purchase of this type of protection has become accepted as one of the practical necessities of regular budgeting by a substantial majority of the households of the country.

If the privileged status of exemption from all but a very few provisions of the insurance code was warranted at the time of planning and development of these programs, it was because they were venturing in a relatively uncharted area.

The Council will conduct a special study of this subject to the end that minimal legislation be supported in the 1959 session of the Legislature which will assure sufficient supervision of these plans that their impact on the economic aspects of health care may be carefully guarded.

Secretary Crownhart: Do you want the rest read, Doctor Collentine?

Doctor Collentine: Yes.

Secretary Crownhart: Number two, the Reference Committee recommends report number two:

The Council recommends that . . .

Since officials of Associated Hospital Service (Blue Cross) have stated their disinterest in sparsely settled areas of the state . . .

Since the current policy of Blue Cross provides varying benefit payments to hospitals in various areas of the state, although the rates charged subscribers are essentially the same . . .

Since it appears that the operations of Blue Cross are not only chiefly metropolitan in character, but, consequently, directed and influenced by metropolitan hospitals . . .

Since the record of Blue Cross has been one of consistent rate increases which, while doubtless justified, may be caused more by metropolitan areas than the less densely settled areas of the state . . .

Since published reports of Blue Cross for 1958 show consistent monthly losses, with the inevitable consequence that further rate increases are indicated in the near future . . .

Since the State Medical Society of Wisconsin and the two hospital associations in Wisconsin stood sponsors of the law under which Blue Cross exists in this state . . .

Since this program grew out of a special study by the State Medical Society in 1937–38 . . .

A special committee to study hospital insurance be created in the image of the 1937–38 committee, which represented the various hospital interests in this state as well as the State Medical Society; that such committee be appropriately financed and instructed to engage in a special study considering such ways and means as may exist to solve some of the hospital economic problems confronting the people in the more sparsely settled areas of the state; to examine current policies with a view to determining ways and means of controlling misuse to the detriment of all concerned; to examine into the bargaining mechanisms between hospitals and Blue Cross, and to offer its recommendations to an ensuing session of this House of Delegates upon these and such other points as may be deemed valid to its study, including the question of whether the public convenience, need, and economy would be served by the organization of a second Blue Cross program which, while operating of necessity throughout the state, would concentrate its efforts principally outside of Milwaukee County.

If this recommendation is approved by the House of Delegates, the Council will proceed forthwith to the development of such a study and will seek the cooperation of its Charitable, Educational, and Scientific Foundation which has already accumulated over $10,000 for the purpose of studying the costs and the possible control of costs of hospitalization. The Council will direct a further appropriation to that Foundation and will ask that the Foundation seek contributions from other interested parties to the end that the study will be detailed and implemented with the skillful assistance of actuaries, accountants, and attorneys especially interested in this area.

Doctor Collentine: Mr. Speaker, is there not an amendment suggested by the Reference Committee on that particular entry?

Secretary Crownhart: It agrees with the desirability of the study as outlined with the addition that lay advisers representing the subscribing public also be included.

Doctor Collentine: Thank you.

Secretary Crownhart: Your Reference Committee has considered Council recommendation number three and recommends its adoption. Recommendation three is:

> Every county medical society is directed to amend its bylaws to the end that it will conduct no functioning operation within the territorial jurisdiction of another county medical society unless with the formal consent of that society and with the approval of the State Medical Society.
>
> If this is not voluntarily accomplished and made effective by the end of 1958, and retroactive as to any existing program in violation of territorial jurisdiction, the Council will, under the provisions of Chapter VI, Section 4, recommend to the 1959 session of the House of Delegates that the charter of such county medical society be forthwith revoked and immediate efforts made to reorganize such county society so that it conforms to Chapter 148 of the Wisconsin Statutes.
>
> The Council will, prior to making any such recommendation to the House of Delegates, conduct conferences or call special meetings with members of such county medical societies to the end that democratic membership activity may supplant autocratic officialdom, if such appears necessary.

Your Reference Committee recommends approval of Council recommendation number four, except that the words, "insurance department," be inserted in place of the words "public officials," and I will read it with those words inserted.

Doctor Collentine: Mr. Speaker, if any further reading is for my personal benefit, I will waive it, and I thank you for reading it. I apologize. I did not mean to be obstreperous at all.

(The question was called for.)

Vice Speaker Lokvam: The question called for is the original motion made, I repeat again, by the Chairman of the Reference Committee. You are familiar with the motion. It has been made and duly seconded. If there is no further discussion, we will call the roll.

Secretary Crownhart: Those voting "Aye" will vote in favor of the report of the Reference Committee. Those voting "No" will be against it.

(Secretary Crownhart called the roll which was as follows:)

Doctor PRENTICE: Number eleven, vote "yes."
Doctor TEMPLETON: Yes.
Doctor WALDKIRCH: I believe I am voting for unity when I vote "Yes."
Doctor OVERMAN: Yes.
Doctor INMAN: Yes.
Doctor DESSLOCH: Yes
Doctor STEEPER: Yes.
Doctor MORRISON: Yes.
Doctor GEARHART: Yes.
Doctor STOOPS: Yes.
Doctor HANK: Yes.
Doctor NORDBY: Yes.
Doctor GOLDEN: Yes.
Doctor SCHRANK: Yes.
Doctor BECK: Yes.
Doctor PICARD: Yes.
Doctor BLOSE: Yes.
Doctor MOLAND: Yes.
Doctor TWOHIG: Yes.
Doctor RATHERT: Yes.
Doctor CAREY: Yes.
Doctor HEIN: Yes.
Doctor TAUGHER: Yes.
Doctor HAMILTON: Yes.
Doctor QUANDT: Yes.
Doctor SCHWARTZ: Yes.
Doctor SATORY: Yes.
Doctor McCANN: Yes.
Doctor JARVIS: Yes.
Doctor ACHESON: Yes.
Doctor GREEN: Yes.
Doctor BOREN: Yes.
Doctor ROSS: No.
Doctor PURTELL: No.
Doctor CHOJNACKI: No.
Doctor SANFELIPPO: No.
Doctor BAKER: No.
Doctor WILLSON: No.
Doctor HOLLENBECK: No.
Doctor OBERBRECKLING: No.
Doctor DREW: No.
Doctor HOUGHTON: No.
Doctor HILLIARD: No.
Doctor SCHMIDT: No.
Doctor RUCH: No.
Doctor LEE: No.
Doctor COLLENTINE: No.
Doctor COLLINS: No.
Doctor COFFEY: No.
Doctor BEEBE: Yes.
Doctor SANDGREN: Yes.
Doctor CARLSON:—(absent or not voting)
Doctor GUTZLER: Yes.
Doctor SIMENSTAD: Yes.
Doctor GEHIN: Yes.
Doctor LEAHY: Not voting.
Doctor SCHULZ: Yes.
Doctor KREUL: Yes.
Doctor HOUSNER: Yes.
Doctor FREEMAN: Yes.
Doctor DAVIS: Yes.
Doctor WHALEN: Yes.
Doctor PEARSON: Yes.
Doctor JEFFRIES: Yes.
Doctor MASON (Sheboygan): Yes.
Doctor DOCKENDORFF: Yes.
Doctor BOSTON: Yes.
Doctor BLANCHARD: Yes.
Doctor BOLGER: Yes.
Doctor SCHWEI: Yes.
Doctor STRAKOSCH: Yes.
Doctor MASON (Marshfield): Yes.
Doctor GOLDSTEIN (General Practice): Yes.
Doctor HIGH (Ophthalmology): No.
Doctor RITCHIE (Pathology): No.
Doctor CLARK (Radiology): Yes.
Doctor CONWAY: (Surgery):—(absent or not voting)
Doctor SARGENT (Urology): No.

Secretary Crownhart: Mr. Speaker, I am informed that Doctor Sorenson registered late. Is it acceptable to the House that his name be called on this roll call?

Vice Speaker Lokvam: What is the pleasure?

Secretary Crownhart: No objection. Doctor Sorenson?

Doctor SORENSON: Yes.

Doctor Sullivan: Mr. Speaker, I don't think it probably makes any difference, but my vote has not been cast.

Secretary Crownhart: Neither has Doctor Miller's. Are you registered? Doctor Miller of Green Bay, Miller, Brown County.

Dr. L. C. Miller: I am duly registered, and my vote is "No."

Vice Speaker Lokvam: Doctor Sullivan, we are waiting with bated breath for your vote—will you please? (Laughter)

Doctor Sullivan: May I ask if I am duly registered in this assembly?

Secretary Crownhart: You are, sir.

Doctor Sullivan: My vote is "No."

Doctor Fons: Is there any further addressing the assembly?

Vice Speaker Lokvam: The vote is not announced.

Doctor Fons: I am sorry.

Vice Speaker Lokvam: While the Secretary is counting the roll, shall we have Doctor Hildebrand, President-Elect, who has a resolution which he wishes to present. Do I hear any objection?

Doctor Hildebrand: Outside in the hall, just above the registration desk, there is a caption placed there by the owners of this building, I presume, to keep their employees in proper perspective. It goes something like this: "Insurance is not limited to Hardware Mutuals." I don't think any more appropriate statement could be made surrounding this meeting.

WHEREAS, The Portage County Medical Society has been an excellent host for this special session of the House of Delegates, and

WHEREAS, Hardware Mutuals Insurance Company has been most generous in providing outstanding facilities which contributed much to the expeditious conduct of the meeting, and its staff has been most cordial, courteous and helpful, and

WHEREAS, The Association of Commerce and local housing facilities of Stevens Point have served well the convenience and comfort of the delegates, now therefore

BE IT RESOLVED, That the House of Delegates of the State Medical Society of Wisconsin express its sincere thanks and appreciation to Hardware Mutuals and the people of Stevens Point for their gracious and enjoyable hospitality.

Mr. Speaker, I move the adoption of this resolution.

Doctor Dessloch: I second the motion.

Vice Speaker Lokvam: The question is the adoption of the resolution by Doctor Hildebrand. May we have a voice vote.

Those in favor "Aye"; contrary. The motion is accepted.

The roll call vote is as follows: "Aye" 55; "No" 22, absent or not voting, 3. Total of 80.* The motion is carried.

Doctor Simenstad: Mr. Speaker, I would like to make a statement, please.

President Fons: I believe I had asked you for the floor.

Vice Speaker Lokvam: I believe you had. Will you accept my apologies, and Doctor Simenstad, would you hold it?

President Fons: Mr. Speaker, Gentlemen of the House: There is no rancor in my heart, no bitterness, because you did not elect through your Reference Committee on resolutions to adopt the resolution which I presented. There is amazement and astonishment, however, within me that you, the legislative body of the State Medical Society of Wisconsin, have elected to go along with a lay secretary instead of with your conferees in medicine. I dislike saying this very, very much, but many, many years of activity as I told you yesterday in official medicine have impressed upon me one factor. That is the vindictive attitude of the Secretary of the State Medical Society, and those are not idle words, gentlemen, as you will see in a moment, towards The Medical Society of Milwaukee County.

Vice Speaker Lokvam: Doctor Fons, may I have this microphone. Doctor Fons, knowing you for a long time and personally, knowing you to be a man of character, knowing you to be a man with ideals, may I say that the Chair, this day, will accept no personal vilification, no recrimination, names may be mentioned, but at all times we shall conduct ourselves as gentlemen, or I shall exercise the prerogative of this office. (Applause)

President Fons: May I tell you, gentlemen, of a statement made at a meeting of the Executive Committee of the Council on August 9, 1958, at Prairie du Chien, Wisconsin.

He said he would push the western boundaries of Milwaukee County to the shores of Lake Michigan, and if some fell in, so much the better.

That is from my own notes, gentlemen, of that

* A recount at the time of publishing these transactions reveals the actual vote to have been 56 "Aye", 22 "No", absent or not voting 3. Total of 81.

meeting which I chairmanned. So I say you have elected to go along with that type of philosophy.

Now knowing that, is there anyone amongst you who voted in the affirmative willing to rise and ask for a reconsideration of the previous question, that is, the vote on the motion to adopt the recommendations of the Reference Committee on resolutions?

Doctor Schwei: Mr. Chairman, may I ask Doctor Fons, is the statement you attribute to Mr. Crownhart, does that appear in the official minutes of the Council meeting? If it does not and was an offhanded remark, I move that this portion of his report be stricken from the record.

President Fons: I have not seen, Doctor, the official record of that Executive Committee meeting, but Doctor Hildebrand was present, Doctor Galasinski, Doctor Arveson was present, and Mr. Murphy and Mr. Crownhart, and I believe Mr. Thayer.

Doctor Dessloch: And Mr. President, I was there.

President Fons: That is right. Doctor Dessloch was there.

Doctor Dessloch: That is not an official recorded minute.

President Fons: I haven't seen any record, Doctor.

Doctor Dessloch: There isn't any.

President Fons: But the statement was made.

Doctor Dessloch: You saw the minutes of that Executive meeting. They were enacted by the Council later.

President Fons: The statement was made, nevertheless.

Doctor Dessloch: I think you are out of order.

President Fons: Gentlemen, you have left me—

Vice Speaker Lokvam: In a moment, sir, I am going to limit this discussion according to the rules established previously. There is no motion before this House for debate. I think if you will proceed, Doctor Fons, with some factual statements and remember my previous admonition.

President Fons: Thank you.

The choice has been yours, gentlemen, so I have been left no alternative. As I remove this ribbon with its attached medallion and place it lovingly in its case, and upon the podium and my badge, it is with a sad and heavy, sorrowful heart that I resign the presidency of the State Medical Society of Wisconsin. You have left me no choice. You have mandated the Council to recommend revocation of the charter of my county society, and in principle, gentlemen, I can no longer serve as your president. (Applause)

Vice Speaker Lokvam: Do I hear a motion to act upon Doctor Fons' statement?

(Cries of "There is no motion necessary.")

Vice Speaker Lokvam: There is no motion to be made. Is there any? Hearing none, Mr. Secretary—

Doctor Willson: Mr. Speaker, I move we adjourn.

Vice Speaker Lokvam: Doctor Simenstad asked for the floor.

Doctor Simenstad: Mr. Speaker and Gentlemen: I am somewhat surprised about this last turn of events. My idea of getting up was to commend the Secretary, his staff, and give them a vote of confidence, and I still think we should do that. I have nothing against Milwaukee County whatsoever, and when they didn't want to accept the majority report this morning, I said that they should. I think that everyone should have a right to be heard, but I don't think that everyone or anyone should have the right to pick up the bat and run home if they don't get their own way.

After all, this is a democratic institution and people can walk out if they wish. That is their prerogative, but certainly the will of the majority should govern, and I would like to move that we give Charlie Crownhart a vote of confidence, the Commission on Medical Care Plans, the excellent staff, and all the people who have been here. I hope, too, that Doctor Fons will think this thing over a little bit because I hope that he will reconsider and remain as the president.

I think that everybody has a right to their opinions. When I was president I didn't get my own way all the time either, and we just have to accept that, but I would like to make the motion not to accept his resignation because I think he should sleep on that, but I would like to move that Charlie Crownhart, the Secretary's office, the Commission on Medical Care Plans and all the staff be given a vote of confidence and a vote of thanks for the very fine work they have done in behalf of the State Medical Society and the leadership that has been exerted by them, by the Council, by the delegates including Milwaukee County in their interesting, if not too harmonious, a meeting.

Vice Speaker Lokvam: You have heard the motion. Is there a second?

Doctor Strakosch: I second the motion.

Vice Speaker Lokvam: The motion has been made and seconded that we adopt Doctor Simenstad's motion.

All those in favor will say "Aye"; contrary. Hearing none, carried.

Now the motion for adjournment.

Doctor McCann: I would like to present a motion to the House for their consideration. One, that we thank Doctor Fons for the way that he has helped us during the time that he has been president of the Society, and, number two, that a committee of three men be appointed to contact Doctor Fons and talk with him, realizing that men under emotional strain will sometimes do things without sound think-

ing, but that they will regret later on, and ask that he have a period or a time to think this over and talk with the committee, and if it is still his decision that he wants to resign the presidency of the State Society, that we accept it, and as we accept it, that we accept it with an attitude of thanks for the way he has helped us during the time that he has been an officer in various chairs of the State Society.

Vice Speaker Lokvam: Is that put forth in the form of a motion?

Doctor Mason (Sheboygan): I second the motion.

Vice Speaker Lokvam: You have heard the motion. Is there any further discussion?

All those in favor of this motion will signify with the usual sign; contrary. Hearing none, it is so ordered.

Some "Noes" were registered. The motion, however, is carried.

Now what is the next order of business? Do I hear a motion to adjourn?

Doctor Beck: Mr. Chairman, who is going to appoint that committee?

Vice Speaker Lokvam: That will be Speaker Leahy who will make that appointment.

The motion is made for adjournment. It has been seconded. Do I hear a vote? All those in favor signify by saying "Aye"; contrary "No." It is so ordered.

(The meeting adjourned at ten twenty-five o'clock.)

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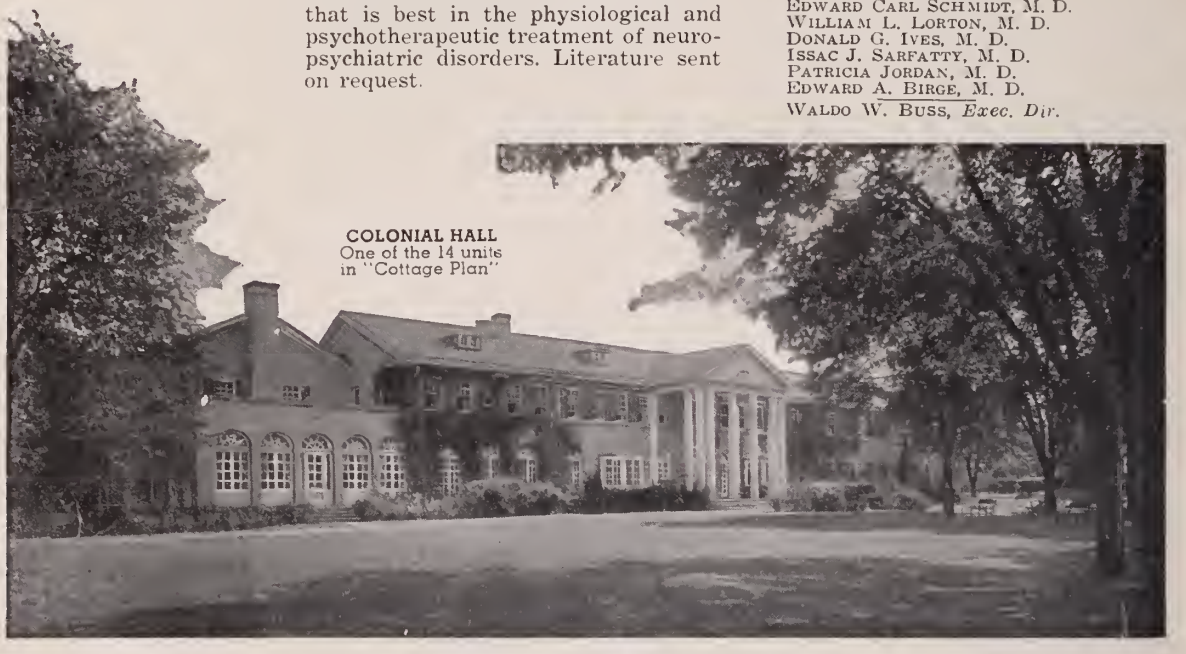

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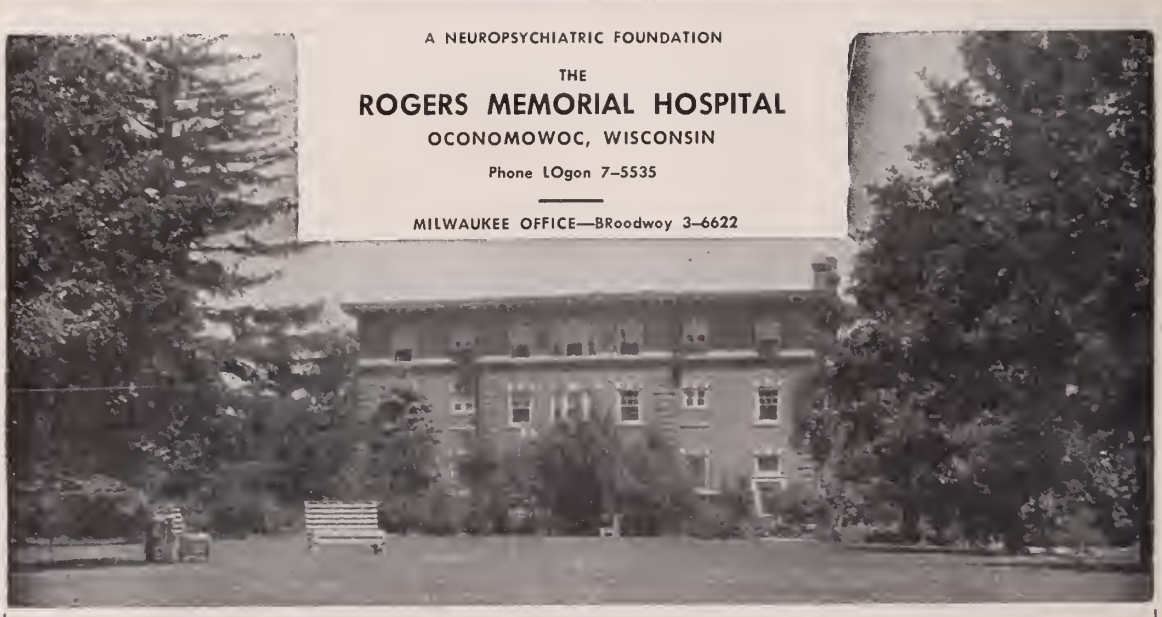

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